

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**7668**  
**CERTIFICATE OF DEATH**

07654

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>			c. LENGTH OF STAY IN 1b <b>41 years</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk (22)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6734 Holabird Avenue</b>				d. STREET ADDRESS <b>1 6734 Holabird Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>++++</b> Last <b>Abramowski</b>				4. DATE OF DEATH Month <b>July</b> Day <b>25th</b> Year <b>1960</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 21, 1895</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		11. IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber Shop Prop.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Barbering (Men)</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Julian Abramowski</b>				14. MOTHER'S MAIDEN NAME <b>Julianna Ulko</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-32-7526</b>		17. INFORMANT <b>Mrs. Jean Abramowski</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>50</b> , to <b>July 25</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>July 23</b> , 19 <b>60</b> , and that death occurred at <b>7:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>33 Dundalk Avenue</b> DATE SIGNED <b>7/27/60</b>							
ACTUAL SIGNATURE <b>David H. Andrew</b> M.D.				PHYSICIAN'S NAME (Type) <b>David H. Andrew, M.D.</b> <b>Baltimore 22, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/28/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Christ Lutheran Cmty.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley</b> <b>Walter Brooks Bradley, Inc., Dundalk 22, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE JUL 28 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07655

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>9 Hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>14 South Bond Street</b>	
3. NAME OF DECEASED (Type or print) First <b>CLAUDE</b> Middle <b>----</b> Last <b>ALEXANDER</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>12</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 9 1886</b>
9. AGE (In years last birthday) <b>74 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Augusta, Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>	
17. INFORMANT Address <b>Clin. REc., VAH Balto 18, Md Ft Howard Division</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>UPPER RESPIRATORY HEMORRHAGE</b> <b>SQUAMOUS CARCINOMA OF BRONCHUS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>Undet.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>1. Abscess of anterior lower chest wall. 2. Arteriosclerotic cardio-vascular disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Form 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19 3:00PM</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 11 12:05AM</b> to <b>July 12 12:05AM</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 12 1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter J. Pijanowski</b>		22b. DATE SIGNED <b>7/12/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER J. PIJANOWSKI, M.D.</b>		22d. ADDRESS <b>VAH BALTIMORE 18, MD FT HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-15-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) (State) <b>Balto. Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy O Wilson</b>		25a. REC'D BY REGISTRAR <b>Arthur S. Kline</b>	
ADDRESS <b>Elroy O Wilson 2004 Orleans St. Balto Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>				c. LENGTH OF STAY IN 1b <b>LIFE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1 BOSLEY RD.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>WILLIAM RALPH ANDERSON</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>JULY 28 1960</b>							
<b>5. SEX</b> <b>M</b>		<b>6. COLOR OR RACE</b> <b>W</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>JAN 2 1882</b>		<b>9. AGE</b> (In years last birthday) <b>78</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>DENTIST</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>DENTIST</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>GREENE COUNTY, MISSOURI</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>LORENZO KING</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>JOSEPHINE EVANS</b>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>486-44-4028</b>		<b>17. INFORMANT</b> <b>Mrs JOHN CETER (DAUGHTER)</b>		Address <b>BOSLEY ROAD COCKEYSVILLE MARYLAND</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>527.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PULMONARY FIBROSIS</b> DUE TO (c) <b>EMPHYSEMA</b>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 DAYS</b> <b>10 YR</b> <b>20 YR</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that</b> (If in this hospital) <b>attended the deceased from 27 July 1960 to 28 July 1960</b> that (I) (we) last saw the deceased alive on <b>22 July 1960</b> and that death occurred at <b>AM</b> , from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <b>Donald O. Wood, M.D.</b>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>7/28/60</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>DONALD O. WOOD M.D.</b>						<b>22d. ADDRESS</b> <b>YORK RD GREENMEADOW, TIMONIUM, MD.</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>				<b>23b. DATE THEREOF</b> <b>AUG 15, 1960</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>MAPLE PARK CEMETERY</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>GREENE COUNTY, MISSOURI</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HENRY W. JENKINS &amp; SONS CO</b>						<b>ADDRESS</b> <b>4905 YORK ROAD BALT 12.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE JUL 29 '60</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hines</b>	

10508

CERTIFICATE OF DEATH

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TIME

PLACE

DECEASED

DECEASED

DOCTOR

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07657

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 3701.4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS <b>6320 Old Washington Rd. 331 S. Ann Street</b>	
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>m.m.i.</b> Last <b>AREN</b>		4. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>1960</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6.29.1893.</b>
9. AGE (In years lost birthday) <b>67</b> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal miner</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOE AREN</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE SHEGRA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>180-03-3299</b>	
17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far advanced bilateral pulmonary tuberculosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>002X</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 years +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Silicosis. Emphysema</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2.19.1957</b> to <b>7.1.1960</b> that I last saw the deceased alive on <b>7.1.1960</b> , and that death occurred at <b>3:16 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.		M.D. <b>Mt. Wilson State Hospital, Mt. Wilson, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/5/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Augustines Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Elkridge, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		24a. REC'D BY REGISTRAR <b>4107 Wilkens Balto. Md.</b>	24b. REGISTRAR'S SIGNATURE <b>JUL 5 '60 Arthur S. Thoma</b>

ANNE SHEPARD

1884

Wm. H. Shepard

Wm. H. Shepard

Wm. H. Shepard

Wm. H. Shepard



1953

COMMUNIST PARTY

Director

Lawrenceville

Director

Lawrenceville

1445 Burton Ave.

1445 Burton Ave.

William Graham Barrett, Jr.

White

4-18-1902

Program

Myr Dear. Miss. (any name)

Proctor, A. Barrett

278-07-6610 Myr Louise Barrett above

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The...  
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Ernest General Services, Towns B. 15.  
Folger Grove  
10-60

10-60

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7696

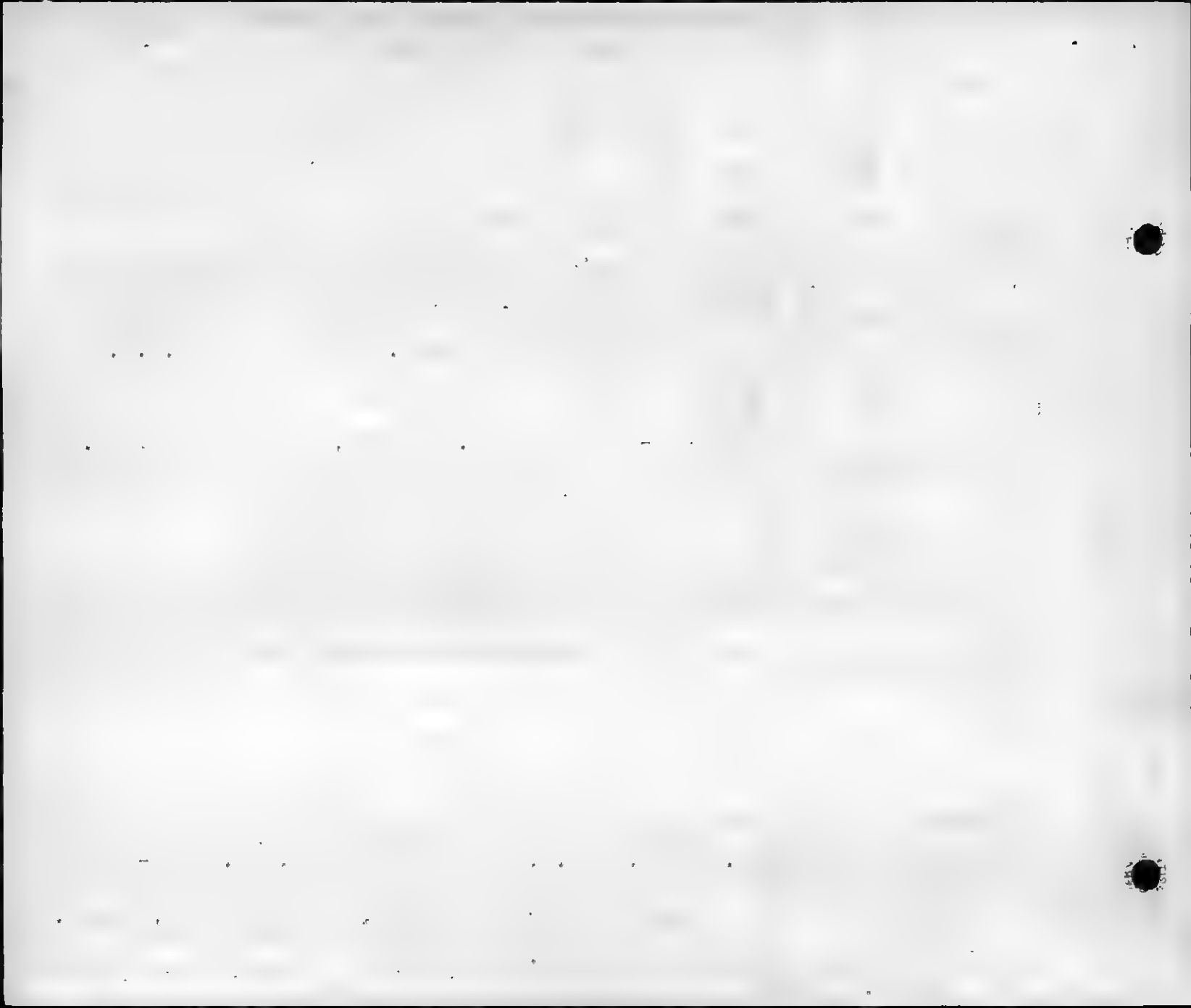
## CERTIFICATE OF DEATH

07659

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Marsh</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>White Marsh</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>Amos</b> Middle <b>Garman</b> Last <b>Bechtel</b>		4. DATE OF DEATH Month <b>July</b> Day <b>4</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 28, 1910</b>
9. AGE (In years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Restaurant Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Bechtel</b>		14. MOTHER'S MAIDEN NAME <b>Ada Garman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>204-07-6219</b>	
17. INFORMANT <b>Anna D. Bechtel, White Marsh, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March</b> , 19 <b>60</b> , to <b>July</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>June 14, 1960</b> , and that death occurred at <b>5:30</b> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William A. Tyson</b> M.D.		ADDRESS (Street, city or town, state) <b>Kingsville, Md.</b> DATE SIGNED <b>7-4-60</b>	
PHYSICIAN'S NAME (Type) <b>William A. Tyson, M.D.</b>		<b>Kingsville, Md.</b> <b>7-4-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/7/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>West Greentree Cemetery, Elizabethtown, Penna.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Tarring</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 7 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>John G. Tarring</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filed with the funeral director, who may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HO **ALL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7678

## CERTIFICATE OF DEATH

Reg. Dist. No.

07660

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>MD</b> <b>St. Paul Street</b> COUNTY <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Relay</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Relay Hill Hospital</b>		d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>E.</b> Last <b>Berlin</b>		4. DATE OF DEATH Month <b>July</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 3, 1887</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min.	IF UNDER 24 HRS. Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Claim agent - Western Maryland Railroad</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penna.</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Berlin</b>		14. MOTHER'S MAIDEN NAME <b>Mary (Ketchikan) Keighley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Daughter: Mary Josephine Berlin Axelson</b>		Address <b>5506 Fifth Ave, Pittsburgh, 32, Penna. Apt. 207</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio-Vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senile psychosis with schizoid personality</b> DUE TO (c) <b>1953</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Many Years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>same as (c)</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 2, 1953</b> , to <b>July 13, 1960</b> , that I last saw the deceased alive on <b>July 12, 1960</b> , and that death occurred at <b>4:50 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Relay, 27, Md.</b> DATE SIGNED <b>7-13-60</b>			
ACTUAL SIGNATURE <b>James Castellano</b> M.D.		PHYSICIAN'S NAME (Type) <b>James Castellano</b>	
22a. BURIAL, CREMATION, REMOVAL, OR OTHER DISPOSITION <b>CREMATION</b>		22b. DATE THEREOF <b>7-14-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cool, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 14 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>			



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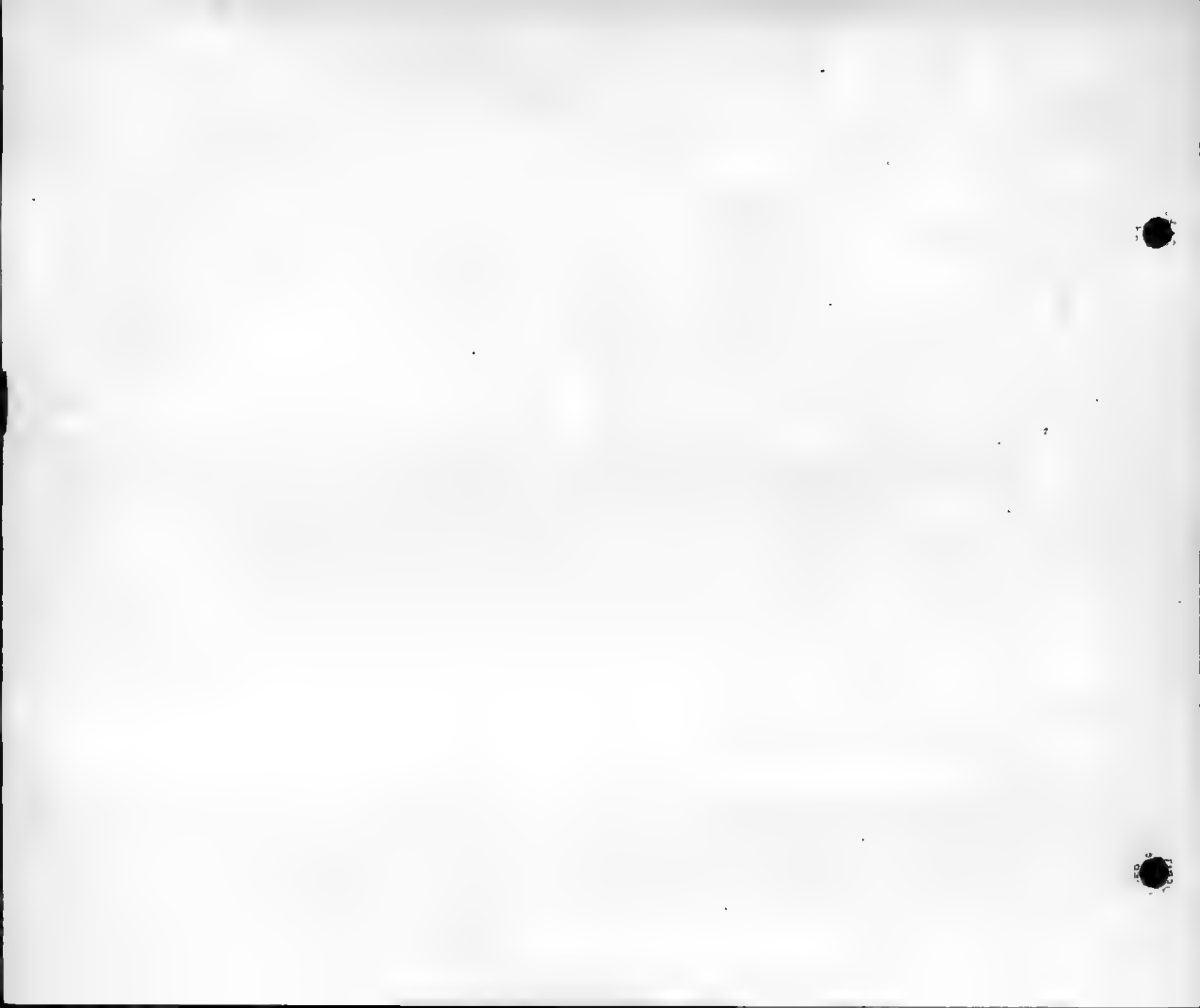
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7697

## CERTIFICATE OF DEATH

07662

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Arm, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Arm, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cliff Manor, Glen Arm, Md.</u>		d. STREET ADDRESS <u>1</u>	
3 NAME OF DECEASED (Type or print) First <u>Victor C.</u> Middle <u>Plandin</u> Last <u></u>		4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15, 1887</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Rubber Broker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rubber Brkr</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Lt. John J. Plandin</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jarrinne Sherranier</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or date of service) <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mr. J. L. Capobianco</u>		Address <u>Orlando, Florida</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>7</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY FORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u></u> Day <u></u> Year <u>19</u> Hour <u></u> a.m. <u></u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)
21 I certify that I attended the deceased from <u>July 11, 1960</u> to <u>July 12, 1960</u> that I last saw the deceased alive on <u>July 11, 1960</u> and that death occurred at <u>6:45</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph F. Lipira M.D.</u>		ADDRESS (Street, city or town, state) <u>8440 Birch Haven Dr., Beltsville, Md</u>	
PHYSICIAN'S NAME (Type) <u>Joseph F. Lipira M.D.</u>		DATE SIGNED <u>7/12/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 15, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>Mr. Cook-Towson, Inc.</u>		ADDRESS <u>100 York St., N.Y.C.</u>	24a REC'D BY REGISTRAR <u>JUL 15 '60</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneaf</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7698

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07663

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>7mth10dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>516 South Collins Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Herbert</b> Middle <b>Franklin</b> Last <b>Bloom</b>				4. DATE OF DEATH Month <b>July</b> Day <b>17</b> Year <b>1960</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 22, 1884</b>		9. AGE in years last birthday <b>76</b> yrs.	10. UNDER 1 YEAR Months <b>7</b> Days <b>17</b>	IF UNDER 24 HRS. Hours <b>17</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>railroad</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penn. R. R.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown NANCY E. Ruhl</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> DUE TO (b) <b>Hypertension Cardiac Vascular Disease</b> DUE TO (c) <b>accident fracture right leg</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Well leg traction applied on 7-6-60</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>On 6-29-60 pt. fell from bed sustaining intertrochanteric frac. of right femur</b>					
20c. TIME OF INJURY Month, Day, Year <b>3:00 a.m. 6-29 1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) (County) (State) <b>Catonsville 28, Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>George M. Kieffer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>		DATE SIGNED <b>July 17, 1960</b>					
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 29, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem. Balt.</b>		22d. LOCATION (City, town, or county) (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. L. Schuchman</b>				24a. REC'D BY REGISTRAR <b>20 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

3512 Frederick Ave. (29)

TO FURNISH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7699

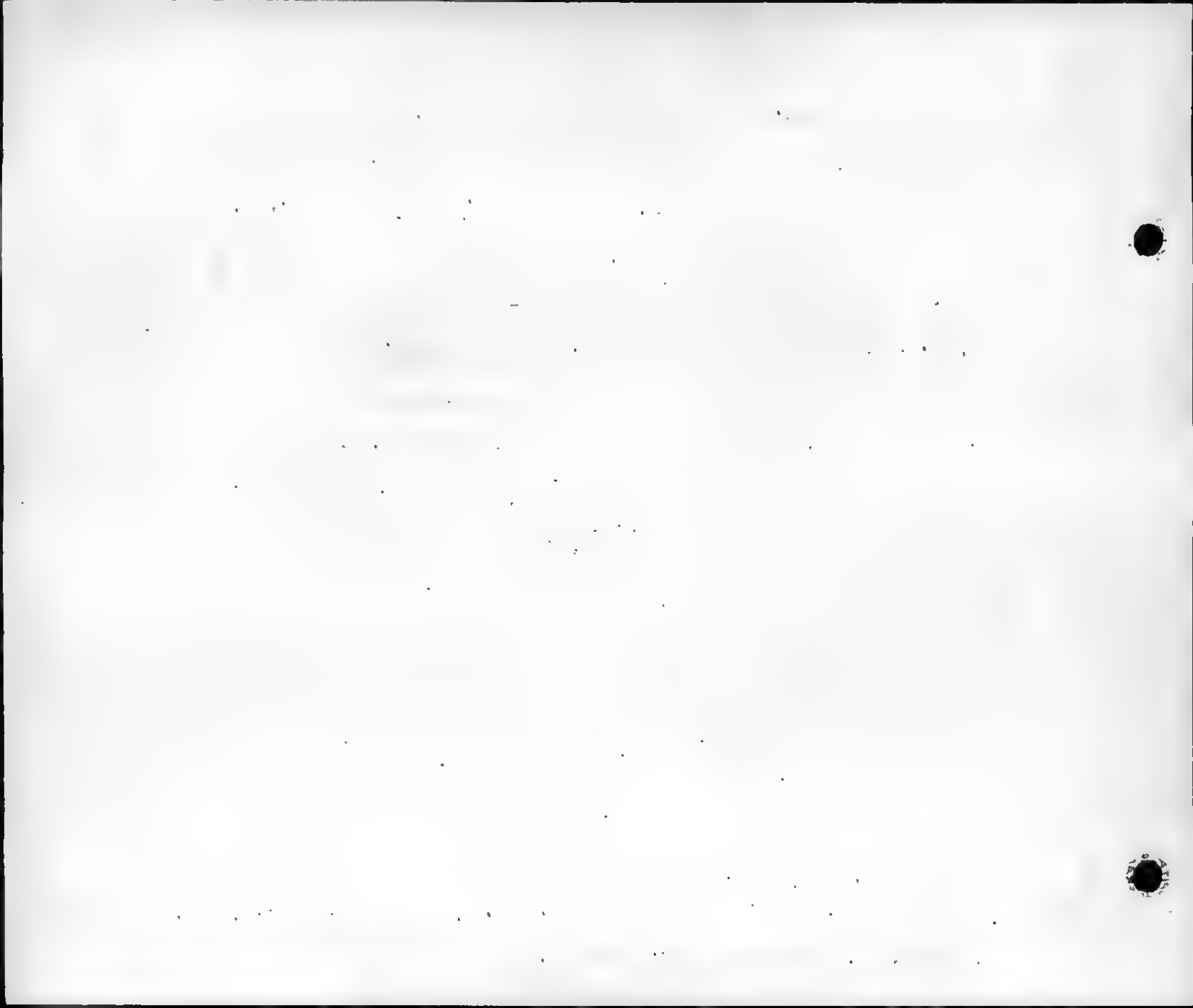
## CERTIFICATE OF DEATH

Reg. Dist. No.

07664

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Baltimore</i> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> <span style="float: right;">b. COUNTY <i>Baltimore</i></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>			c. LENGTH OF STAY IN lb <i>Parkville</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7709 Chestnut Ave.</i>				e. STREET ADDRESS <i>7709 Chestnut Ave.</i>			
<b>3. NAME OF DECEASED</b> (Type or print) First <i>Howard</i> Middle <i>A.</i> Last <i>Boehm</i>				<b>4. DATE OF DEATH</b> Month <i>July</i> Day <i>7</i> Year <i>19 60</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-17-1892</i>			
9. AGE (In years last birthday) <i>68</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Postman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Post Office</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				13. FATHER'S NAME <i>Henry Boehm</i>			
14. MOTHER'S MAIDEN NAME <i>Zella Smith</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>			
16. SOCIAL SECURITY NO <i>WW 1</i>		INFORMANT <i>Mrs Irene L. Boehm</i>		Address <i>same</i>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cirrhosis of the liver</i> 4:30 PM DUE TO <i>Cirrhosis of the liver</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i> DUE TO <i>Hypertension</i> (c) <i>Hypertension</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>EC</i>			
20f. (City or town) <i>EC</i>		(County) <i>EC</i>		(State) <i>EC</i>			
21. I certify that I attended the deceased from <i>6/7-1-60</i> to <i>7-7-60</i> , that I last saw the deceased alive on <i>7-1-60</i> , and that death occurred at <i>9:00 PM</i> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <i>7709 Chestnut Ave. Baltimore, Md.</i>				DATE SIGNED <i>Arthur L. Hume</i>			
ACTUAL SIGNATURE <i>Leonard J. Ruck</i>		PHYSICIAN'S NAME (Type) <i>277 R. R. RIZICKA</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>7-5-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cem.</i>			
22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		(State) <i>Md.</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Rd.</i>				24a. REC'D BY REGISTRAR DATE <i>JUL 6 '60</i>			
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>				24c. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7669

## CERTIFICATE OF DEATH

Reg. Dist. No.

07665

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN IB <b>3 Mo.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Res. 1971 Haselmere Road</b>		d. STREET ADDRESS <b>1971 Haselmere Road</b>	
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>EARL</b> Last <b>BOLTON</b>		4. DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 15, 1901</b>
9. AGE (In years (month) (day) yrs. <b>58</b>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-Employed in Shoe Repair Shop</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Bolton</b>		14. MOTHER'S MAIDEN NAME <b>Cornelia Bolton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>224-09-4988</b>	
17. INFORMANT <b>Mrs. Harry E. Bolton</b>		Address <b>1971 Haselmere Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ARTERIO SCLEROTIC C.V. DISEASE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>1 Yr.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 20, 1960</b> to <b>Jan 21, 1960</b> , that I last saw the deceased alive on <b>Jan 20, 1960</b> , and that death occurred at <b>11:45 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stephen C. Mackowiak M.D.</b>		ADDRESS (Street, city or town, state) <b>6714 Holbrook Ave Baltimore Md</b>	
PHYSICIAN'S NAME (Type) <b>STEPHEN C. MACKOWIAK</b>		DATE SIGNED <b>7-21-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-23-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Jacobs</b>		22d. LOCATION (City, town, or county) (State) <b>Rockingham Co. Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN J. DUDA</b>		ADDRESS <b>7922 Wise Ave. 22, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE JUL 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>L. S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Director, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07666

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LUTHERVILLE</b>		c. LENGTH OF STAY IN 1b <b>3 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>COLLEGE MANOR</b>			d. STREET ADDRESS <b>CHARLES &amp; 33rd STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>AGUSTA BRANDAU</b>			4. DATE OF DEATH Month Day Year <b>JULY 13, 1960 19</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 7, 1877</b>	9. AGE (In years last birthday) <b>83 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MARYLAND</b>	
13. FATHER'S NAME <b>MARTIN MAYFORT</b>			14. MOTHER'S MAIDEN NAME <b>CATHERINE KNIER</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>1646 Roundhill Road Balto. 18 Md.</b> <b>MR. A. GORDON BRANDAU</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerosis due to Plaque</b> (c) <b>Bag tied over head to commit suicide</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs.</b> <b>Sudden</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>7/13/60</b>	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>JULY 16, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>GREENMOUNT CREMATORY</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS INC. BALTO. MD.</b>		24a. REC'D BY REGISTRAR <b>JUL 15 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Howard</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07667**

**7701**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore County</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Bradshaw</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institutional Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air RD 2</u> d. STREET ADDRESS <u>Rural</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Graham</u> Middle <u>R</u> Last <u>Brown</u>				<b>4. DATE OF DEATH</b> Month <u>7</u> Day <u>2</u> Year <u>1960</u>									
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Black</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Feb 18 - 1943</u>		<b>9. AGE</b> (in years last birthday) <u>17</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>17</u> Days <u>17</u>		<b>IF UNDER 24 HRS.</b> Hours <u>17</u> Min. <u>17</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Student</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>—</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Tulliston —</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>			
<b>13. FATHER'S NAME</b> <u>Graham Brown Jr</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Eleanor Williams</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>none</u>				<b>17. INFORMANT</b> <u>Graham Brown Jr</u> Address <u>Bel Air RD 2</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>421.1</u> <b>DUE TO</b> <u>Arterio Sclerosis</u> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <u>—</u> <b>DUE TO</b> <u>—</u> <b>(c)</b> <u>—</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>—</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>													
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)									
<b>20c. TIME OF INJURY</b> Hour <u>19</u> o. m. <u>—</u> p. m. <u>—</u> Month, Day, Year <u>7-6-60</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
<b>ACTUAL SIGNATURE</b> <u>Wm. J. [Signature]</u> <b>M.D.</b>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			<b>DATE SIGNED</b> <u>7-3-60</u>				
<b>EXAMINER'S NAME (Type)</b>						<b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			<b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>7-6-60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Lakewood</u>				<b>22d. LOCATION (City, town, or county)</b> <u>Benson Hfd. Md</u> <b>(State)</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. J. [Signature]</u>						<b>ADDRESS</b> <u>Benson, Md</u>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>JUL 8 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles S. [Signature]</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any entry is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

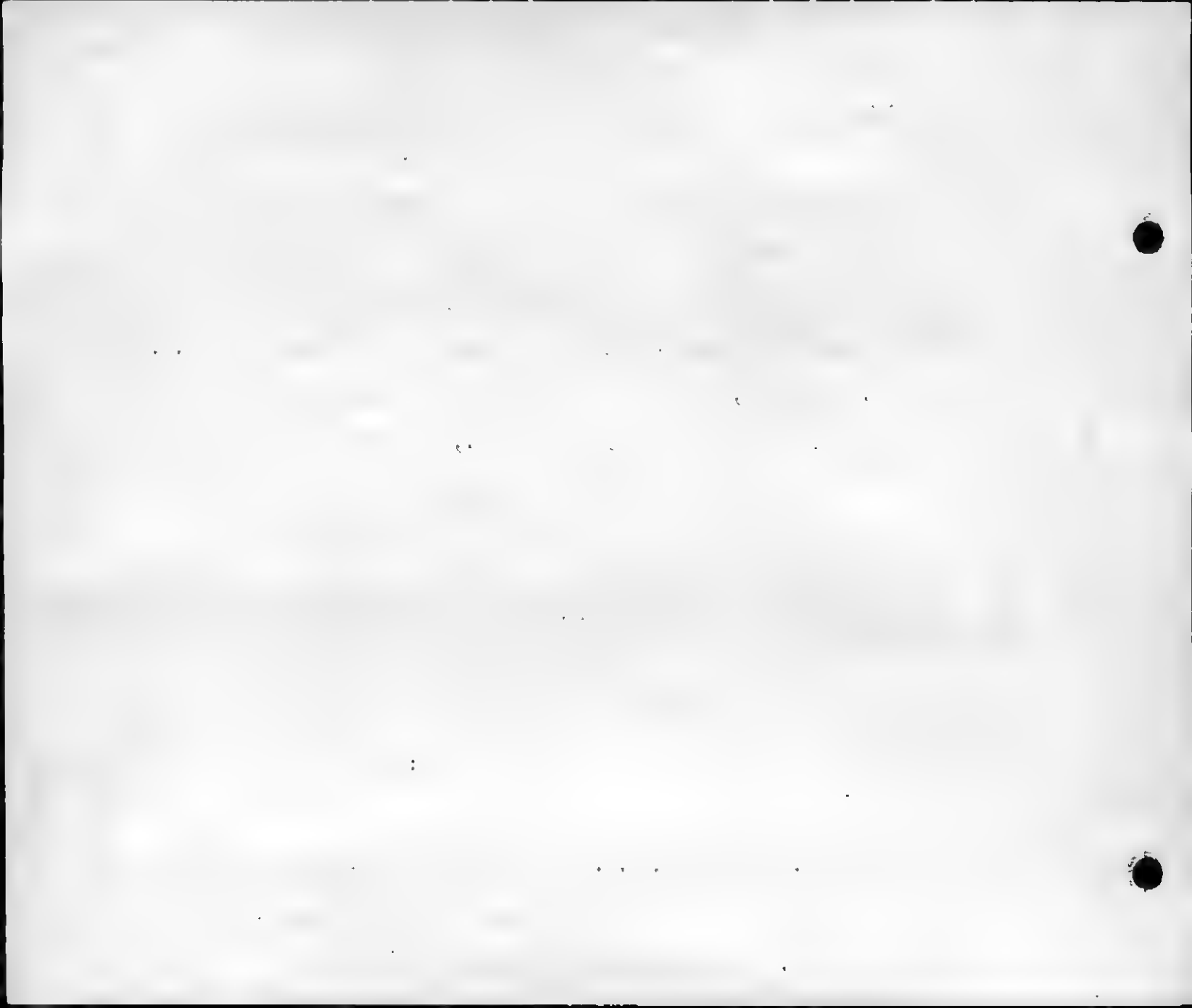
**CERTIFICATE OF DEATH**

07668

7702

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>900 CATHEDRAL STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>W</b> Last <b>BURGESSER</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>17</b> Year <b>19 60</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 15, 1892</b>	
9. AGE (In years lost birthday) <b>68</b> yrs.		10. UNDER 1 YEAR Months <b>68</b> Days <b>0</b> Hours <b>0</b> Min.		11. UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REAL ESTATE BROKER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>REAL ESTATE</b>			
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			
13. FATHER'S NAME <b>RAYMOND W. BURGESSER, SR</b>				14. MOTHER'S MAIDEN NAME <b>NANCY RICHARDSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>WW I 214-09-6651</b>		17. INFORMANT <b>CLIN REC., VAH BALTO 18, MD FT HOWARD DIVISION</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <b>Hypertrophy and dilatation of heart; Cardiac Decompensation; Diabetes Mellitus; Generalized arteriosclerosis</b>				19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 20 11:30 PM</b> to <b>July 17 1960</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 17 1960</b> , and that death occurred at <b>11:30 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Walter J. Pijanowski</i>				22b. DATE <b>7/19/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>WALTER J. PIJANOWSKI, M.D.</b>				22d. ADDRESS <b>VAH BALTO 18, MD FT HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-21-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook Blight Inc. 6009 Harford Rd Balto Md</b>				25a. REC'D BY REGISTRAR <b>JUL 22 1960</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HO... OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.



7703

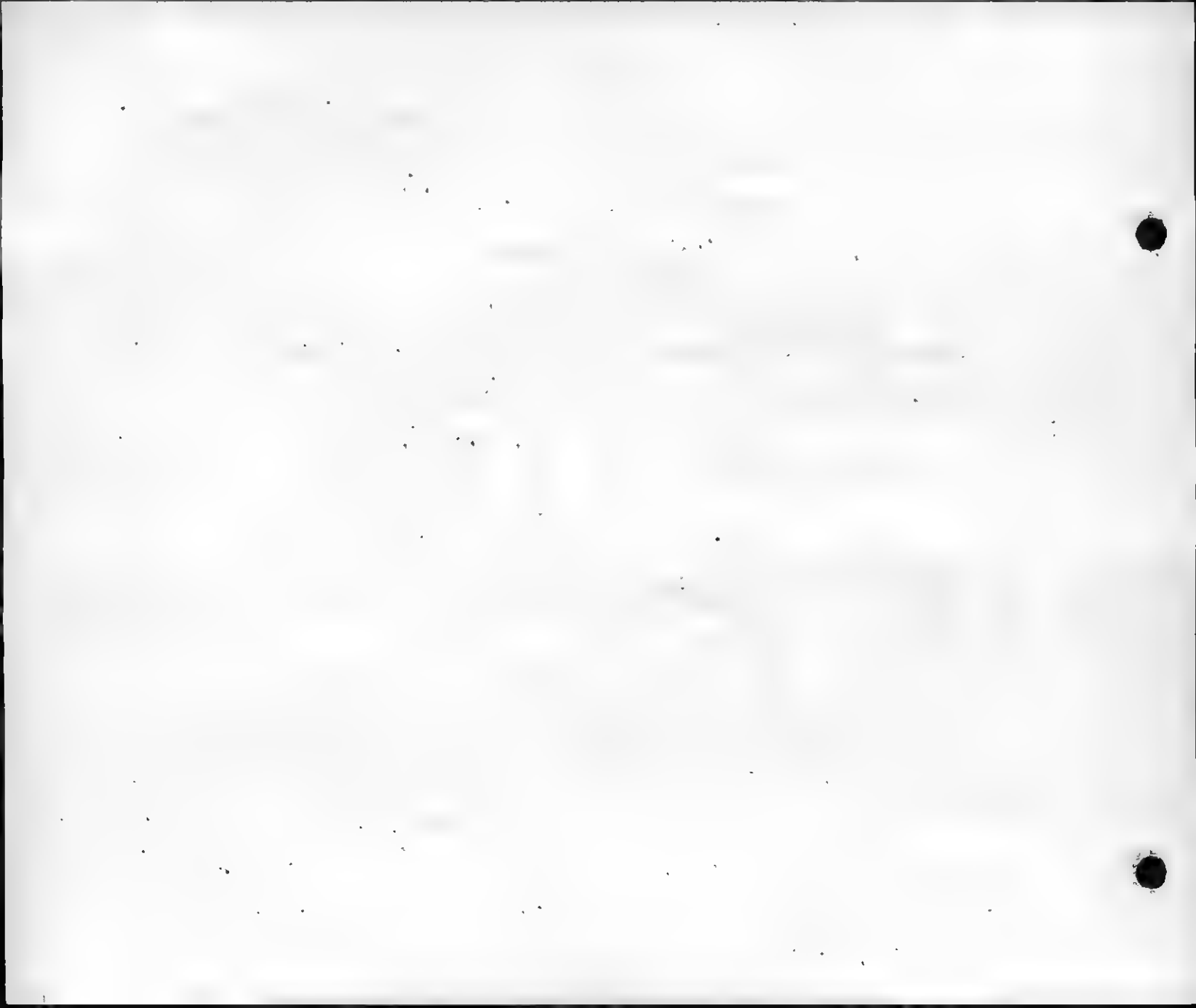
## CERTIFICATE OF DEATH

07669  
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baynesville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baynesville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8616 Oakleigh Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>Mr. John Michael Burke</i>		4. DATE OF DEATH <i>July 21st 1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 31, 1894</i>
9. AGE (In years last birthday) <i>66</i> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Bailer Maker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i>	
11 BIRTHPLACE (State or foreign country) <i>USA</i>		12 CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Patrick Burke</i>		14. MOTHER'S MAIDEN NAME <i>Catherine ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO. <i>Mrs. Anne M. Burke</i> Address <i>same</i>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of lungs</i> DUE TO (b) <i>metastases to brain</i> DUE TO (c) <i>Cardiovascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 20</i> , 19 <i>59</i> to <i>date</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>July 20</i> , 19 <i>60</i> , and that death occurred at <i>16 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Leonard Y. Ruck</i> M.D.		ADDRESS (Street, city or town, state) <i>8467 Greenwood Rd</i> DATE SIGNED <i>7/22/60</i>	
PHYSICIAN'S NAME (Type) <i>Leonard Y. Ruck, Jr. M.D.</i>		<i>Louison 4/4</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/25/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard Y. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR <i>DATE JUL 25 '60</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kears</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7704

## CERTIFICATE OF DEATH

07670

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Broadway Road</b>		d. STREET ADDRESS <b>Broadway Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Thomas</b> Last <b>Burnham</b>		4. DATE OF DEATH Month <b>July</b> Day <b>10</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 19, 1896</b> 9. AGE (In years last birthday) <b>63</b> IF UNDER 1 YEAR: Months <b>6</b> Days <b>3</b> Hours <b>10</b> Min. <b>10</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Builder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b> 11. BIRTHPLACE (State or foreign country) <b>Baltimore County</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas C. Burnham</b>		14. MOTHER'S MAIDEN NAME <b>Maryl L. Harmon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>W.W.I</b>		16. SOCIAL SECURITY NO <b>W.W.I</b> INFORMANT <b>Mrs. Frank T. Gney, Broadway Road, Lutherville</b> Address <b>Lutherville</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>Arteriosclerosis + arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Diabetes mellitus</b> DUE TO <b>Diabetes mellitus</b> (c) <b>Diabetes mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), or (c). <b>None</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <b>7</b> Day <b>13</b> Year <b>1960</b> Hour <b>7</b> a.m. <b>10</b> p.m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) <b>Lutherville</b> (County) <b>Baltimore</b> (State) <b>Md.</b>
21. I certify that I attended the deceased from <b>7-1-10</b> to <b>7-10-10</b> that I last saw the deceased alive on <b>7-9-10</b> and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above. ADDRESS (State, city or town, state) <b>Lutherville, Md.</b> DATE SIGNED <b>7-11-60</b>			
ACTUAL SIGNATURE <b>James G. Satter</b> M.D.		PHYSICIAN'S NAME (Type) <b>James G. Satter, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>7-13-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Satters Baptist Cemetery</b>	22d. LOCATION (City, town, or county) <b>Baltimore County, Md.</b> (State) <b>Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. C. Ok-Towson, Inc., 1050 York Rd. Towson</b>		24a. REC'D BY REGISTRAR <b>JUL 14 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

7705

07671

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
c. LENGTH OF STAY IN 1b <b>5 YEARS</b>				d. STREET ADDRESS <b>2905 GARRISON AVE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>				e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>MARCIA</b> Middle <b>BURNHAM</b> Last				4 DATE OF DEATH Month <b>JULY</b> Day <b>18</b> Year <b>1960</b>			
5 SEX <b>FE</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-11-1871</b>	
9. AGE (In years last birthday) <b>89</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>JAMES GOODWIN</b>				14. MOTHER'S MAIDEN NAME <b>MARY GRIFFIN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-16-5707-1</b>		17. INFORMANT <b>Frank E. Smith Jr. - Cockeysville, Md</b>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Cardio Vascular Disease</b> DUE TO (b) <b>5 years.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>5-9-1955</b> to <b>7-18-1960</b> , that (I) (we) last saw the deceased alive on <b>7-15-1960</b> , and that death occurred at <b>1:35 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Walter T. Kees</b>				M D ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>7/18/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>				22d. ADDRESS <b>COCKEYSVILLE, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7-20-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 19 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur E. Frank</b>	

MEDICAL CERTIFICATION



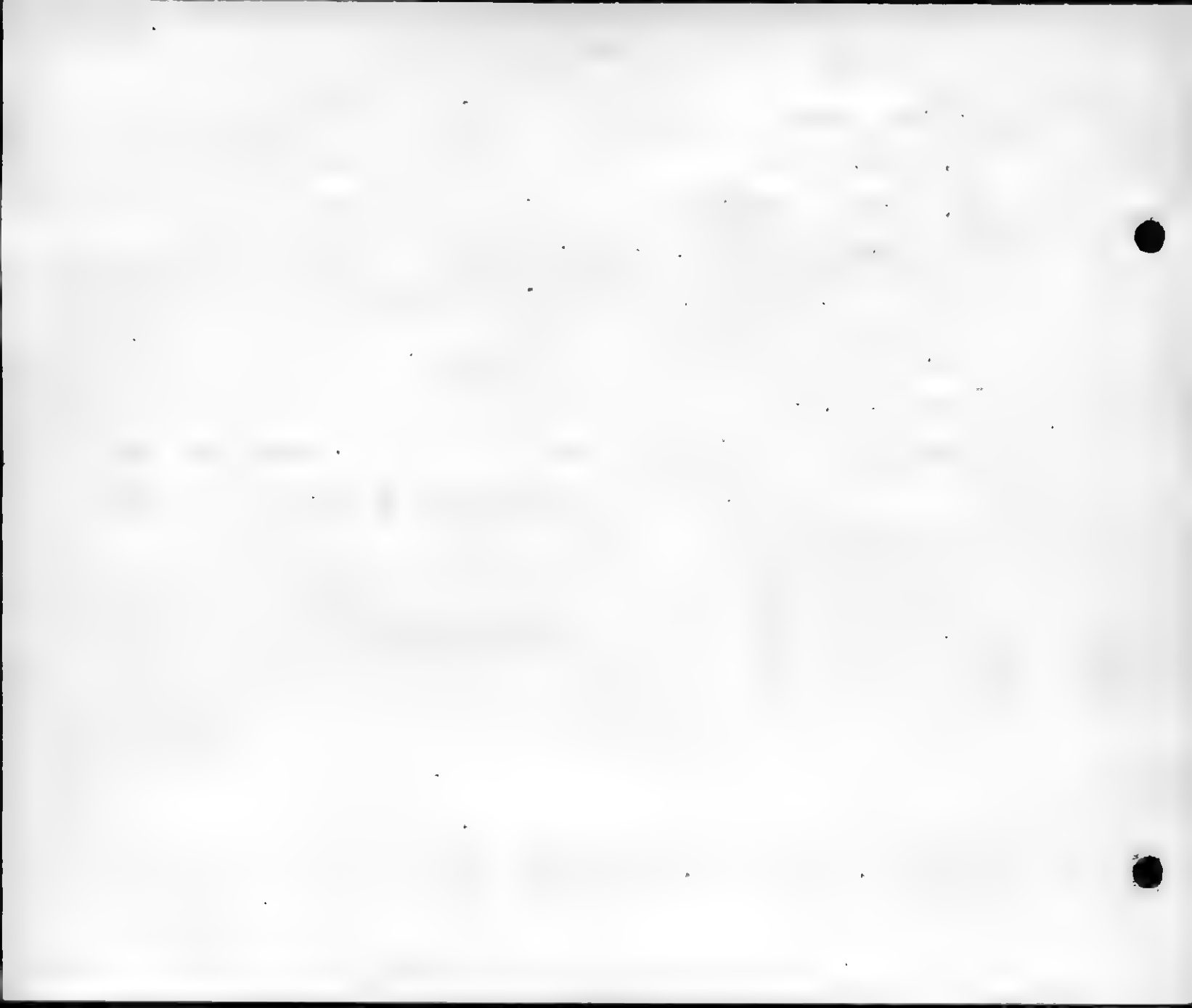
7706

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City 30</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LAWRENCE ALBERT BURNS</b>				4. DATE OF DEATH <b>July 19 1960</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 4. 1880</b>	9. AGE (In years last birthday) <b>79</b> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN J. BURNS</b>				14. MOTHER'S MAIDEN NAME <b>MARY R. REED</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b> [If yes, give war or dates of service]				16. SOCIAL SECURITY NO. <b>Unknown</b>			
				INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs +</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Far Advanced Pulmonary TB. Acute left Pyelonephritis</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-1-1959</b> to <b>7-19-1960</b> that I last saw the deceased alive on <b>7-19-1960</b> , and that death occurred at <b>8:37 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED							
ACTUAL SIGNATURE <b>William Newcomer</b>				M.D. <b>Mt. Wilson, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>7-22-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>McCully Funeral Home 130 E. 1st St</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 22 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



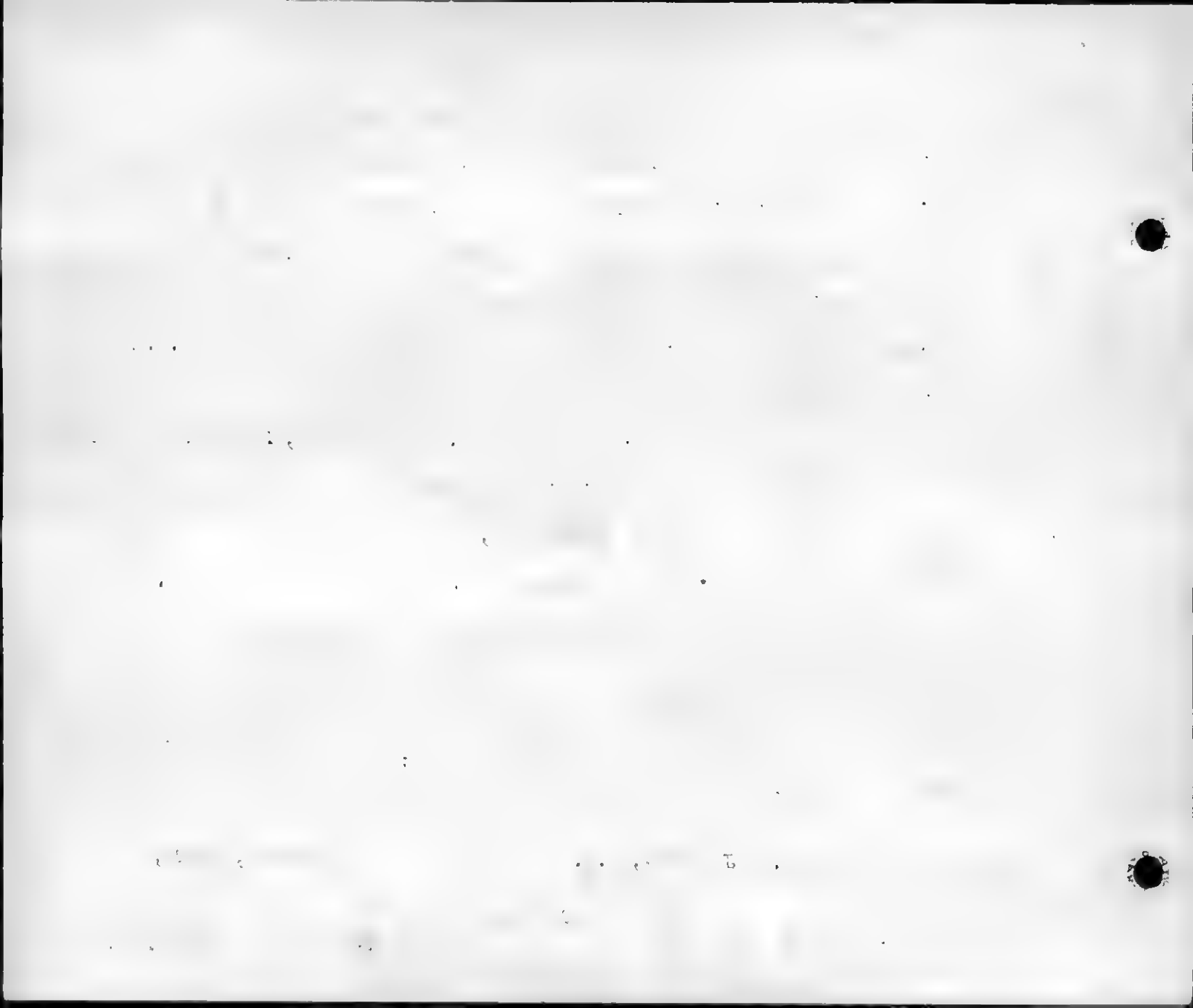
7707

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

07673

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>CONNECTICUT</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WEST HARTFORD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>44 HILLSBORO DRIVE</b>	
3. NAME OF DECEASED (Type or print) First <b>EDWIN</b> Middle <b>W</b> Last <b>BURRITT</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>12</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 17 1888</b>
9. AGE (In years last birthday) <b>72 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CIVIL ENGINEER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	11. BIRTHPLACE (State or foreign country) <b>WYOMING</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>CHARLES H BURRITT</b>	
14. MOTHER'S MAIDEN NAME <b>CLARA E WHEELER</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW I</b>	
16. SOCIAL SECURITY NO. <b>578 32 5110</b>		17. INFORMANT <b>CLIN REC. VAH BALTO 18, MD FT HOWARD DIVISION</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBAR PNEUMONIA RIGHT LUNG</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>CEREBRAL THROMBOSIS, RIGHT</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b> <b>15 DAYS</b> <b>UNKNOWN</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 27 1960</b> to <b>July 12 1960</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 12 1960</b> , and that death occurred at <b>12:15 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Walter J. Pijanowski</i>		22b. DATE SIGNED <b>7/13/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER J. PIJANOWSKI, M.D.</b>		22d. ADDRESS <b>VAH FT HOWARD DIVISION, BALTO, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7-16-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Ellsworth Armacost</i>		25a. REC'D BY REGISTRAR <b>JUL 14 '60</b>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneass</i>		26. ADDRESS <b>Ellsworth Armacost 4600 Liberty Heights Ave Baltimore</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corrob papers, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

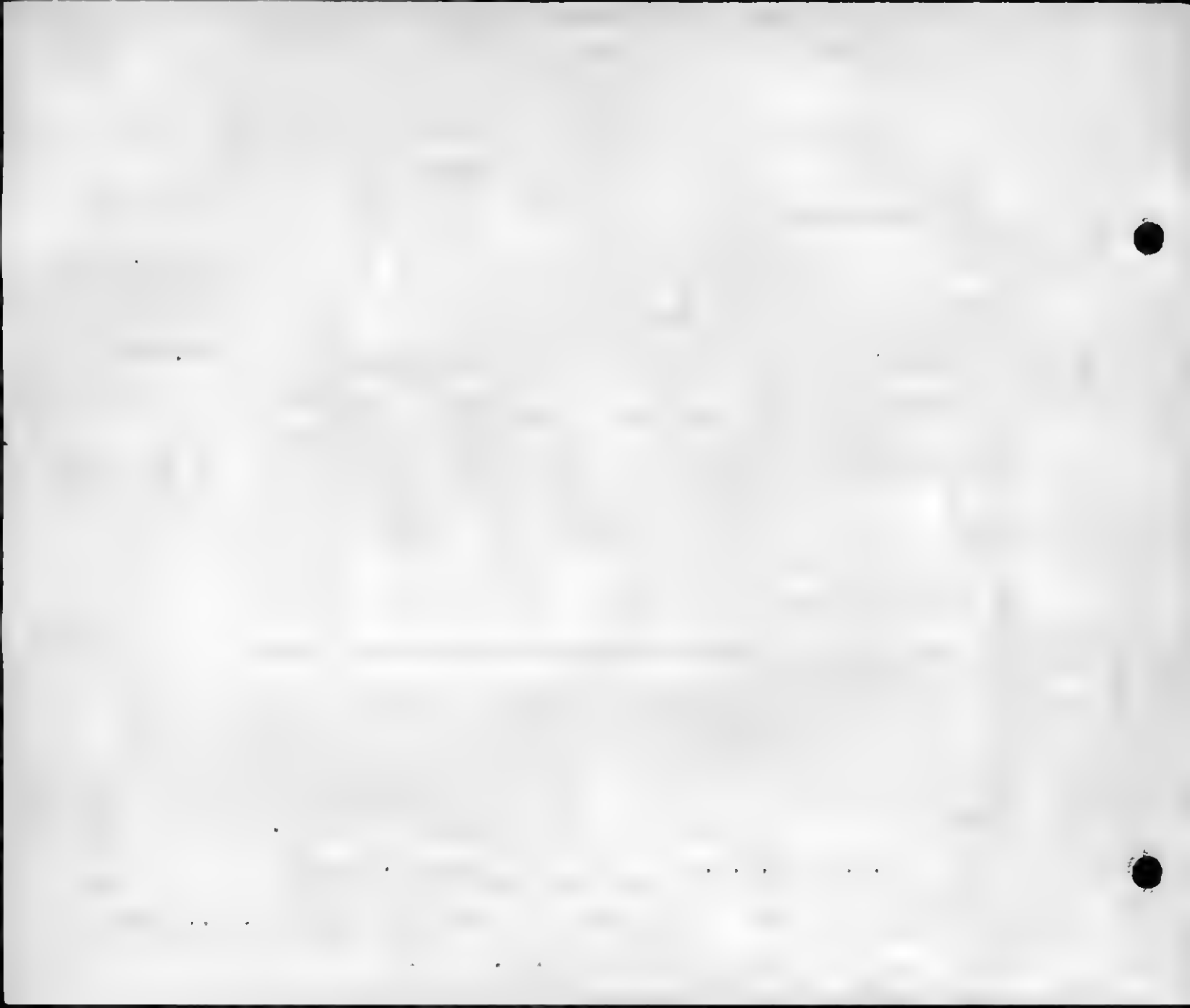
7708

## CERTIFICATE OF DEATH

Reg. Dist. No.

07674

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>4 Essex (21)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>954 Renfrew Street</b>		d. STREET ADDRESS <b>1 954 Renfrew Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Rosy</b> Middle <b>+++</b> Last <b>BUTLER</b>		4. DATE OF DEATH Month <b>July</b> Day <b>8th</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 6, 1882</b>
9. AGE (in years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>South Wales</b>	
11. BIRTHPLACE (State or foreign country) <b>So. Wales</b>		12. CITIZEN OF WHAT COUNTRY? <b>So. Wales</b>	
13. FATHER'S NAME <b>James Temblett</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Ann Hatch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. <b>BERTRAM BUTLER</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <b>Cerebral thrombosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 mos</b> <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/1</b> , 19 <b>60</b> , to <b>7/8</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>7/1</b> , 19 <b>60</b> , and that death occurred at <b>7:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>J. J. Platt</b> M.D. <b>434 Eastern Blvd.</b> <b>8/9/60</b> PHYSICIAN'S NAME (Type) <b>J. J. Platt, M.D.</b> <b>Essex 21, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/11/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Brooks Bradley</b>		ADDRESS <b>Dundalk 22, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 12 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

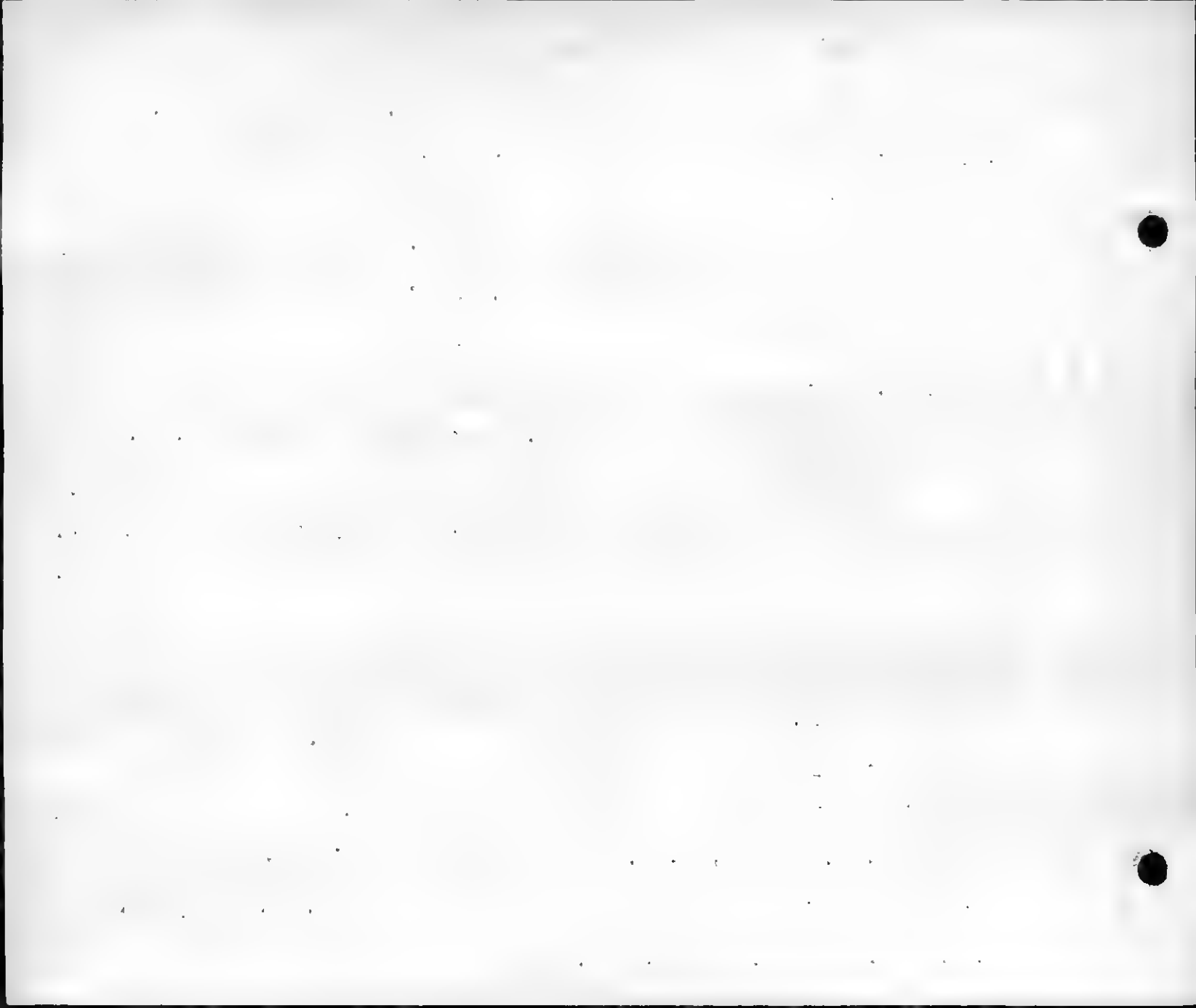


7709

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown Rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown Rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Butler Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Vincent</b> First <b>Talbott</b> Middle <b>Caples Sr.</b> Last		4. DATE OF DEATH <b>July 13,</b> 19 <b>60</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 28, 1872</b>
9. AGE (In years, months, days, hours, minutes) <b>87</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert F. Caples</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Shipley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Mr. Robert Caples Reisterstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Hypertensive Arteriosclerotic C-V Disease 9 yrs.</b> (c) <b>Diabetes 23 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>none</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I attended the deceased from <b>11-20-37</b> , 19 <b>37</b> , to <b>7-13-60</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>7-13-60</b> , 19 <b>60</b> , and that death occurred at <b>5 P M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>D. D. Caples</b>		ADDRESS (Street, city or town, state) <b>6 Hanover Road</b> DATE SIGNED <b>7-15-60</b>	
PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>		<b>Reisterstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 16, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Dover Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Eline &amp; Sons Reisterstown, Md.</b> ADDRESS		24a. REC'D BY REGISTRAR <b>DATE JUL 18 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>



TO NO. 1 OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 1

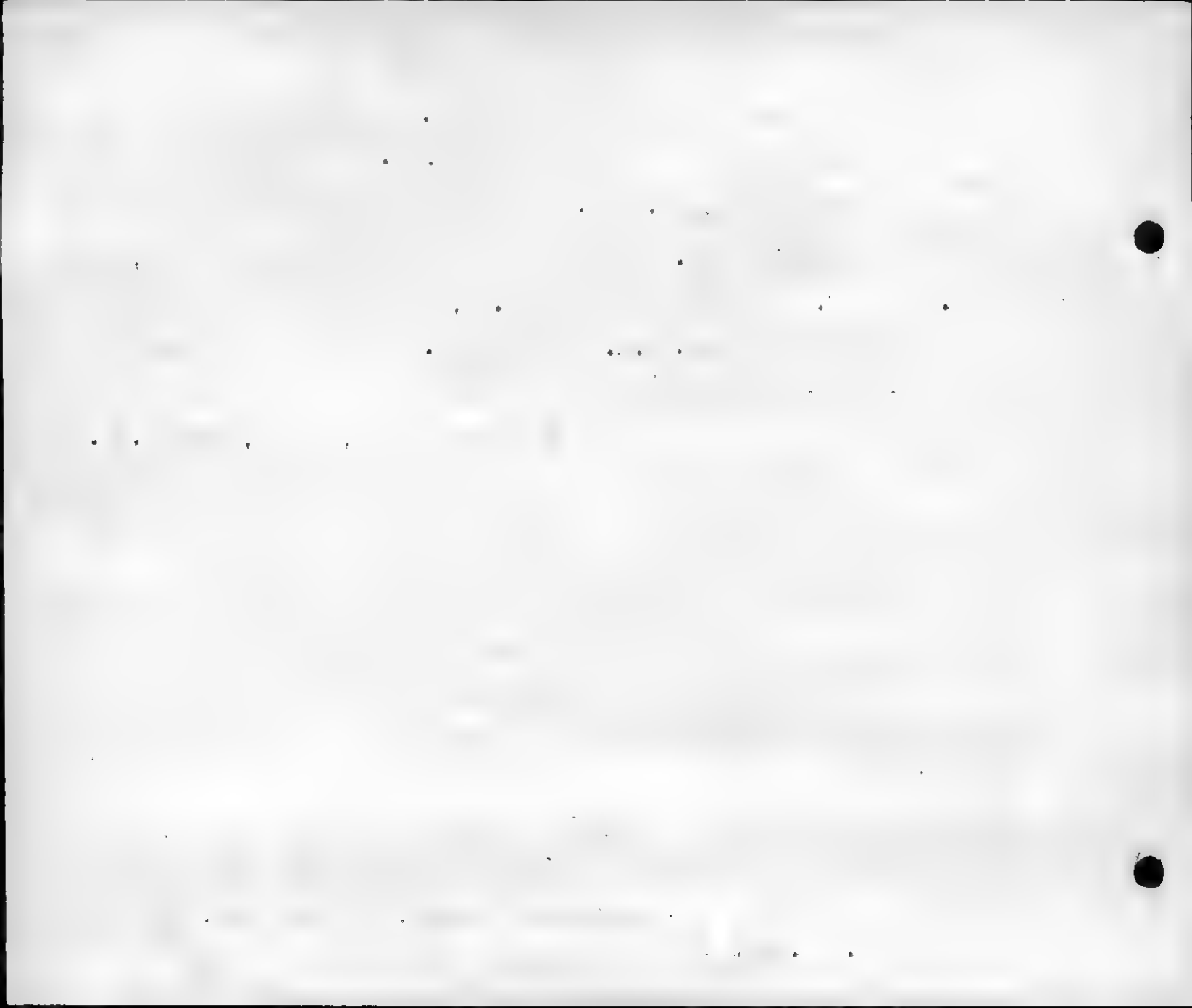
VR A15 (4)  
15M 11/59

7710

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07676

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltes.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltes.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady Nook Conv.Home.</b>				d. STREET ADDRESS <b>Formerly of 325 Yale Ave</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>L.</b> Last <b>Carter</b>				4. DATE OF DEATH Month <b>July</b> Day <b>25</b> Year <b>1960</b>			
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 28, 1882</b>	9. AGE (In years last birthday) <b>78</b> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conductor</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conductor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Pa. R.R.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>-----Carter</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT Address <b>Mr Allan Gunter, Box 82, Pratt W.Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stenocardiac Endocard Disease</b> DUE TO <b>5 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour <b>a m.</b> p m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>7/10</b> to <b>7/25</b> , 19 <b>60</b> , that (1) (we) last saw the deceased alive on <b>7/25</b> 19 <b>60</b> and that death occurred at <b>6:30 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Theodore T. Witzke M.D.</b>				22b. DATE <b>7/26/60</b>		22c. PHYSICIAN'S NAME (Type) <b>THEODORE T. WITZKE M.D.</b>	
22d. ADDRESS <b>429 S Chester St Md.</b>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/27/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cmty.</b>		23d. LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Fun. Dir. 4101 Edmondson Ave</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 27 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Knease</b>	



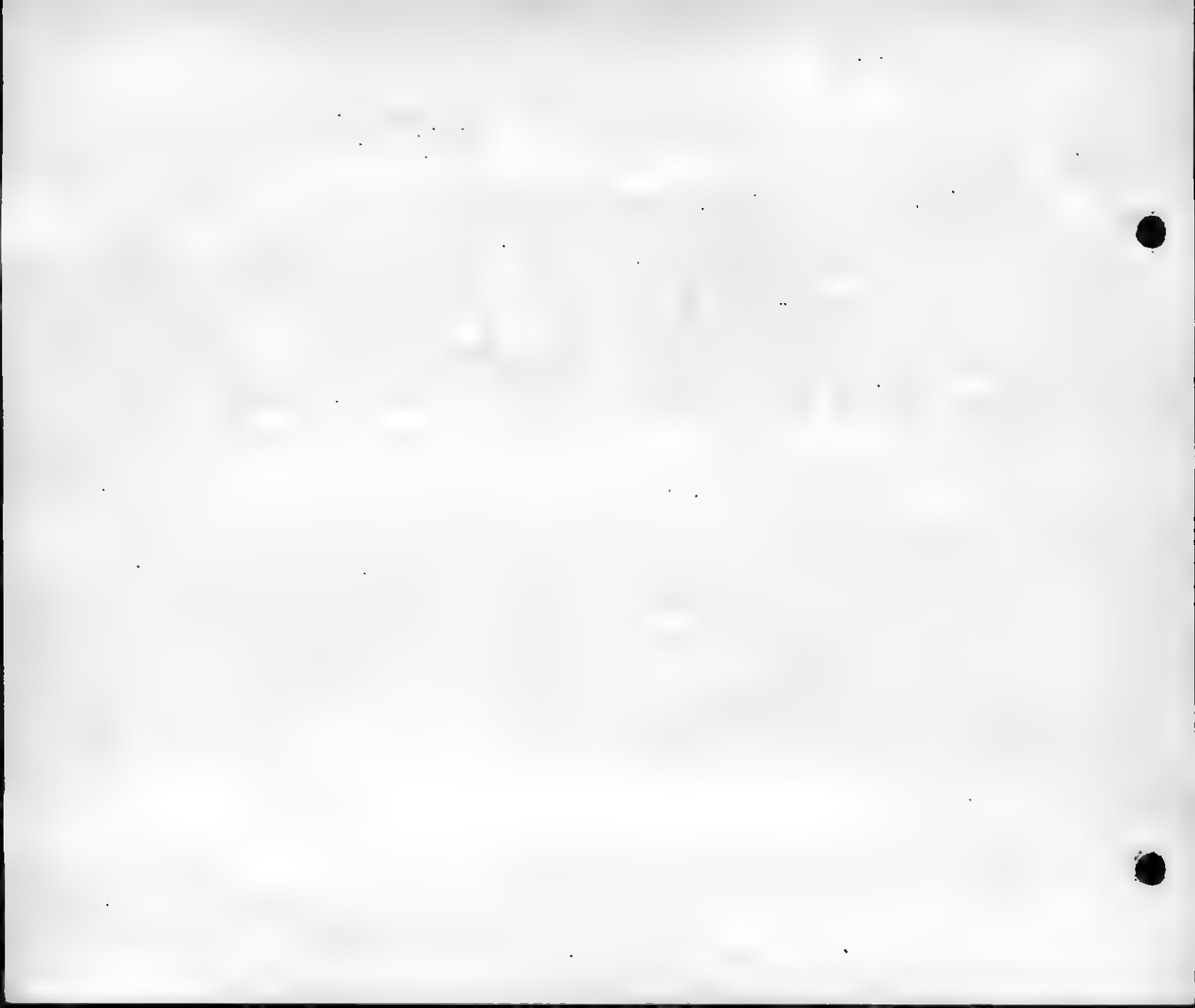
7711

MD MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07677

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Abtington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Shady Nook Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>BERTHA</i> Middle <i>M.</i> Last <i>CHIPMAN</i>		4. DATE OF DEATH Month <i>July</i> Day <i>7</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 29 1877</i>
9. AGE (in years last birthday) <i>83</i> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Gettysville Harford Co.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George W. Streett</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Y. Mason</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>No</i>	
17. INFORMANT <i>Mrs Ellwood M. Campbell</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> DUE TO (b) <i>Generalized Arterio Sclerosis 50 yrs</i> DUE TO (c) <i>Hypocarditis - Corrupte Emboli</i> 3 days		INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 5 1960</i> to <i>July 7 1960</i> , that (I) (we) last saw the deceased alive on <i>July 7 1960</i> , and that death occurred at <i>9 A.M.</i> from the causes and on the date stated above			
22a. SIGNATURE <i>Wetherbee Fort</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Wetherbee Fort</i>		22d. ADDRESS <i>1118 St. Paul St. Balto. Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7-90-60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins &amp; Sons, Co.</i>		25. REC'D. BY REGISTRAR <i>1118 St. Paul St.</i>	
ADDRESS <i>4905 York Road</i>		25b. REGISTRAR'S SIGNATURE <i>A. Mason</i>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

7712

7712

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07678

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>12 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. STREET ADDRESS <b>227 N Hammonds Ferry Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>PURR</b> Middle <b>LEE</b> Last <b>CHOATE</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>18</b> Year <b>1960</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 23, 1916</b>	9. AGE (in years last birthday) <b>44 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USULA OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Barber Shop</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PURR LEE CHOATE, SR.</b>				14. MOTHER'S MAIDEN NAME <b>DAISY BELCKER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES</b> <b>PTE</b>		16. SOCIAL SECURITY NO <b>214-12-7311</b>		17. INFORMANT <b>CLIN. RECORDS VA HOSP BALTO MD FT HOWARD DIV</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>EDEMA OF THE LUNGS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>PORTAL CIRRHOSIS OF THE LIVER</b> (c) <b>BLEEDING ESOPHAGEAL VARICES</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>GASTRITIS AND DUODENITIS</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (a) (this hospital) attended the deceased from <b>July 6</b> 19 <b>60</b> to <b>July 18</b> 19 <b>60</b> that (b) (he) last saw the deceased alive on <b>July 18</b> 19 <b>60</b> and that death occurred at <b>6:35 AM</b> from the causes and on the date stated above							
22a. SIGNATURE <i>Walter J. Pijanowski</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>7/18/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>WALTER J. PIJANOWSKI, M.D.</b>		22d. ADDRESS <b>VAH BALTO MD. FT HOWARD DIVISION</b>					
23a. BURIAL, CREMATATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-21-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck Funeral Home</b>		ADDRESS <b>5305 Harford Rd. Balto, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 21 '60</b>		25b. REGISTRAR'S SIGNATURE <i>Charles F. Hume</i>	

MEDICAL CERTIFICATION







7714

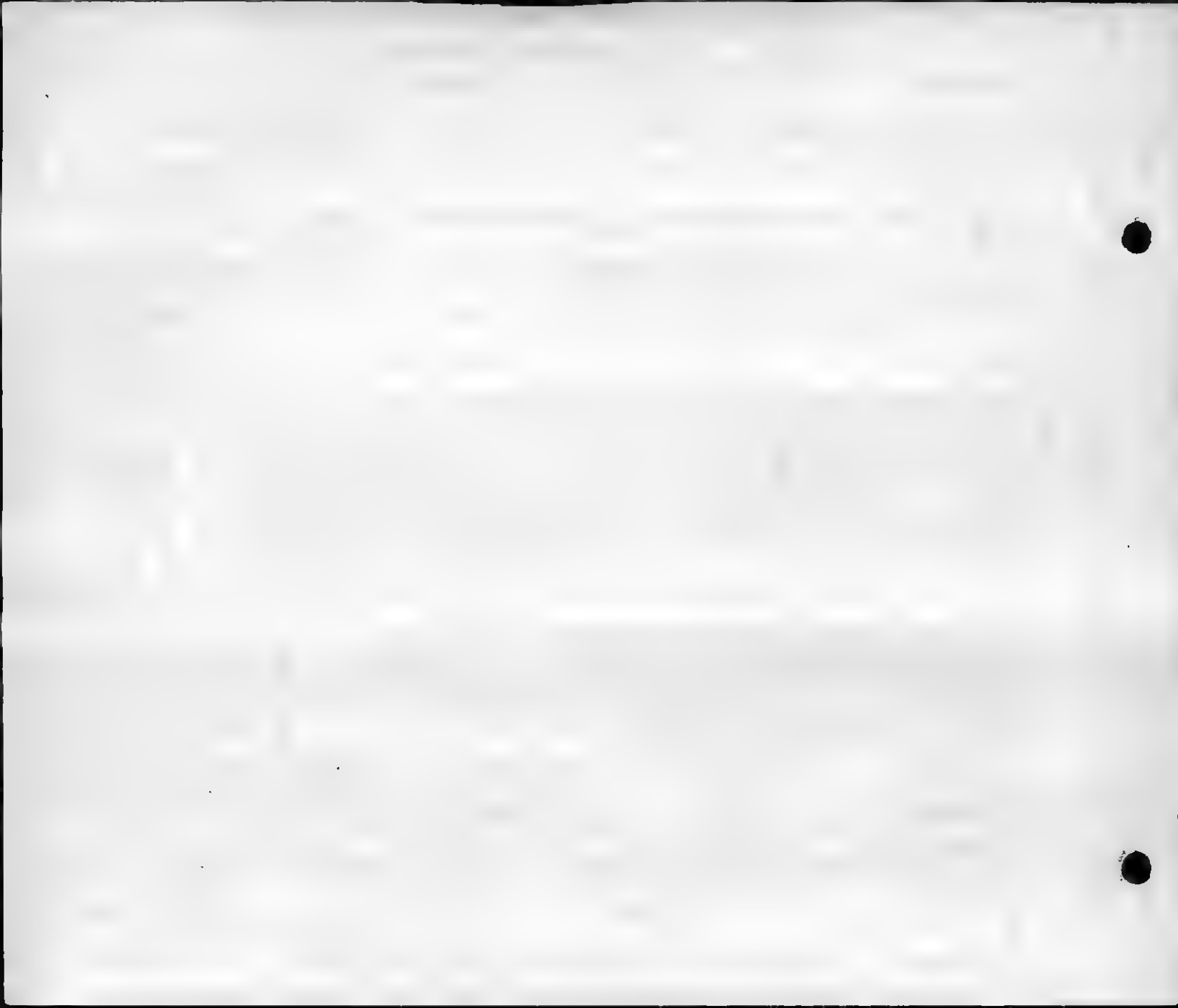
CERTIFICATE OF DEATH

Reg. Dist. No. 07680

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>A. A. Co.</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines - Nursing Home</u>		d. STREET ADDRESS <u>Box - 99 - Rt - # 2</u>	
3. NAME OF DECEASED (Type or print) First <u>Nora</u> Middle <u>Clark</u> Last <u>Clark</u>		4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 28 - 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Woman Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Reformatory</u>	
11. BIRTHPLACE (State or foreign country) <u>Severn md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Asberry Clark</u>		14. MOTHER'S MAIDEN NAME <u>Anna L. Pay</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>120.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Hypertensive Carditis - 2 years in Hospital</u> DUE TO (c) <u>10 yr</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/12</u> 19 <u>60</u> , to <u>7/3</u> 19 <u>60</u> , that I last saw the deceased alive on <u>7/2</u> 19 <u>60</u> , and that death occurred at <u>1:15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6307 Frederick Ave.</u> DATE SIGNED <u>7/3/60</u>			
ACTUAL SIGNATURE <u>William K. Gallager</u> M.D.		PHYSICIAN'S NAME (Type) <u>William K. Gallager M.D. Baltimore - 28 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-6-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>A. A. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert K. Ware</u> ADDRESS <u>Singletown Funeral Home - Robert K. Ware</u>		24a. REC'D BY REGISTRAR DATE <u>Jul 7 '60</u> 24b. REGISTRAR'S SIGNATURE <u>William K. Gallager</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HO L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)  
15M 11/59

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7715  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07681

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Balt.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PARKVILLE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7714 BAGLEY AVE.</b>				d. STREET ADDRESS <b>321 SMALL COURT.</b>			
3. NAME OF DECEASED (Type or print) <b>EMMA DIETRICH CLASSEN</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>13</b> Year <b>1960</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>FEB. 11, 1883</b>	9. AGE (In years last birthday) <b>77</b> yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>D.H.</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>DIETRICH</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ( <i>if yes, give war or dates of service</i> )				16. SOCIAL SECURITY NO			
17. INFORMANT <b>JOHN A. DIETRICH, 321 SMALL COURT, CATONSVILLE</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral artery sclerosis</b> <b>334-X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>July 12, 1960</b> to <b>July 13, 1960</b> , that (I) (we) last saw the deceased alive on <b>July 12, 1960</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>William J. ...</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/13/60</b>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JULY 16/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LODGE PARK</b>		23d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WITKE FUN. DIR. 4101 EDMONDSON AVE.</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>JUL 18 60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>			



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 TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 7716  
 CERTIFICATE OF DEATH

07682  
 Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD				b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. LENGTH OF STAY IN 1b 45 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS 621 Pennsylvania Ave				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Louie Freeman Cole				4. DATE OF DEATH 7 4 1960							
5. SEX M		6. COLOR OR RACE Col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/18/1906		9. AGE (In years last birthday) 54 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor				10b. KIND OF BUSINESS OR INDUSTRY Mfg. Plant				11. BIRTHPLACE (State or foreign country) W. Va.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Charles Cole				14. MOTHER'S MAIDEN NAME Flora Madden			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO None				17. INFORMANT Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of chest wall 1979-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 5 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
				20f. (City or town)				(County) (State)			
21. I certify that I attended the deceased from 5/20, 1960 to 7/4, 1960, that I last saw the deceased alive on 7/4, 1960, and that death occurred at 12:30 A.M. from the causes and on the date stated above. A.M. ADDRESS (Street, city or town, state) DATE SIGNED											
ACTUAL SIGNATURE William Newcomer				M.D. Mt. Wilson, Maryland							
PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent											
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal + Burial				22b. DATE THEREOF 7/9/60				22c. NAME OF CEMETERY OR CREMATORY Duffields Cemetery			
22d. LOCATION (City, town, or county) (State) Reedson Jefferson Co. West Va.											
23. FUNERAL DIRECTOR'S SIGNATURE Donald Eickles				ADDRESS Harpers Ferry, W. Va.				24a. REC'D BY REGISTRAR JUL 7 '60			
								24b. REGISTRAR'S SIGNATURE Arthur S. Hines			







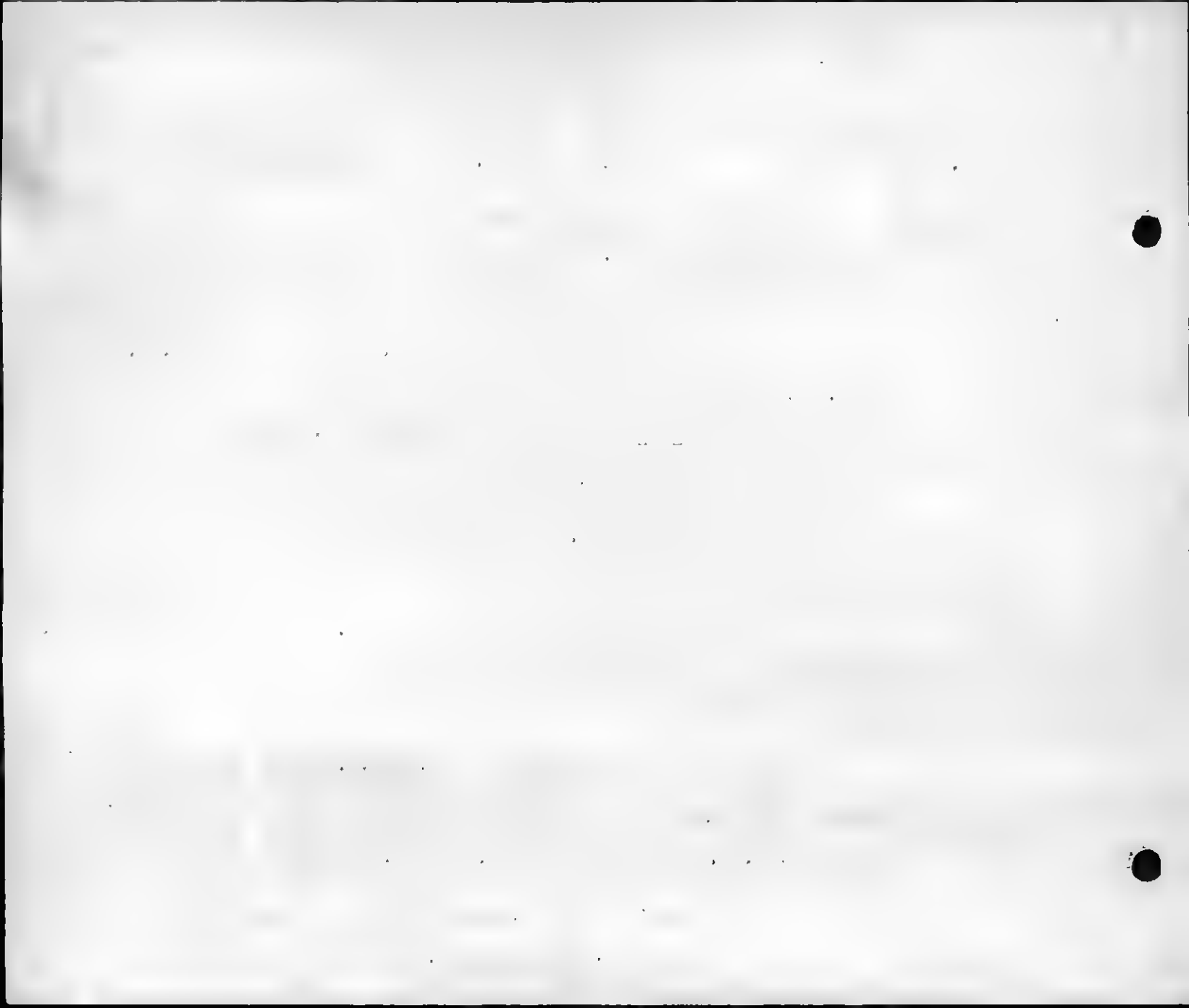
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7718

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07684

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>				c. LENGTH OF STAY IN 1b <b>20 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>				e. STREET ADDRESS <b>none</b>			
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>M.</b> Last <b>Cone</b>				4. DATE OF DEATH Month <b>7</b> Day <b>29</b> Year <b>19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/7/08</b>		9. AGE (In years last birthday) <b>52</b> yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hospital attendant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Rochester, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Fred. E. Cone</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-38-3209</b>		17. INFORMANT <b>Records on file at Mt. Wilson State Hospital</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO <b>hypertension.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary tuberculosis, inactive.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 3/4 hours</b> <b>10 years.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			20g. (County)			20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 23</b> <b>1960</b> to <b>July 29</b> <b>1960</b> , that (I) (we) last saw the deceased alive on <b>July 29</b> <b>1960</b> , and that death occurred at <b>2:15 P.M.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>William Newcomer</b>				22b. DATE SIGNED <b>7/29/60</b>		22c. PHYSICIAN'S NAME (Type) <b>WILLIAM NEWCOMER, M. D.</b>	
22d. ADDRESS <b>Mt. Wilson, Maryland</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>not used</b>		23b. DATE THEREOF <b>7/31/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Graceland Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Graceland, New York</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Krause Funeral Home</b> <b>Horis S. Krause</b>				25a. REC'D BY REGISTRAR <b>AUG 1 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	



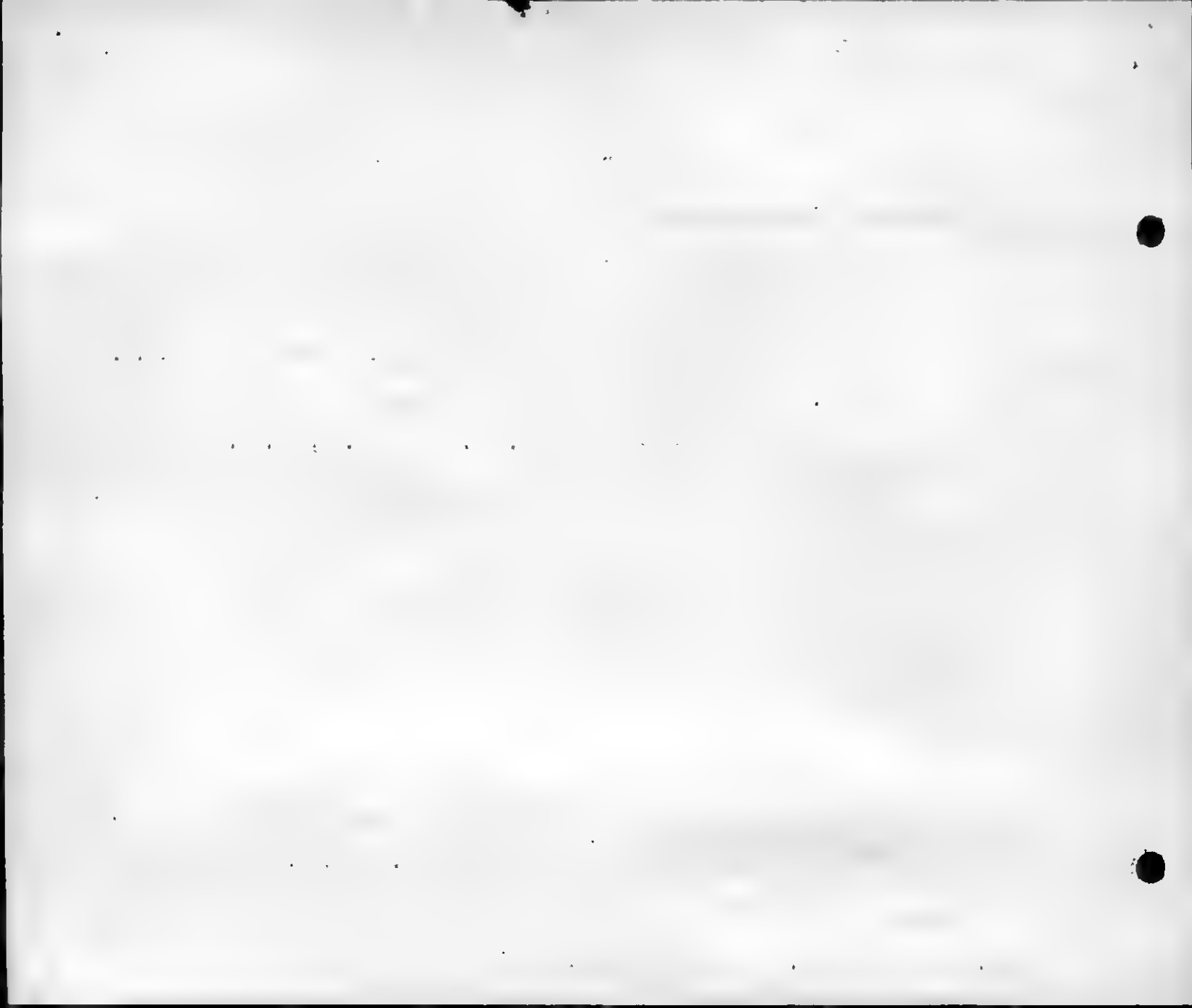
7719

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

07685

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>65 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>F.</b> Last <b>COOPER</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>2</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/12/94</b>
9. AGE (In years last birthday) <b>66</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Doctor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Physician</b>	
11. BIRTHPLACE (State or foreign country) <b>Kansas City, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Calvin L. Cooper</b>		14. MOTHER'S MAIDEN NAME <b>Mary Shannon</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW I</b>		16. SOCIAL SECURITY NO <b>123-03-8774</b>	
17. INFORMANT <b>Clin. Rec. VAH, Balto. 18, Md. Ft. Howard Division</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ASTROCYTOMA GRADE III LEFT FRONTAL REGION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BRONCHOPNEUMONIA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 MONTHS</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 28, 1960</b> to <b>July 2, 1960</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 2, 1960</b> and that death occurred at <b>12 AM</b> from the causes and on the date stated above			
22a. SIGNATURE <b>George C. McElrick</b>		22b. DATE SIGNED <b>7/2/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>George C. McElrick</b>		22d. ADDRESS <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>7-6-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc.</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 6 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7670

CERTIFICATE OF DEATH

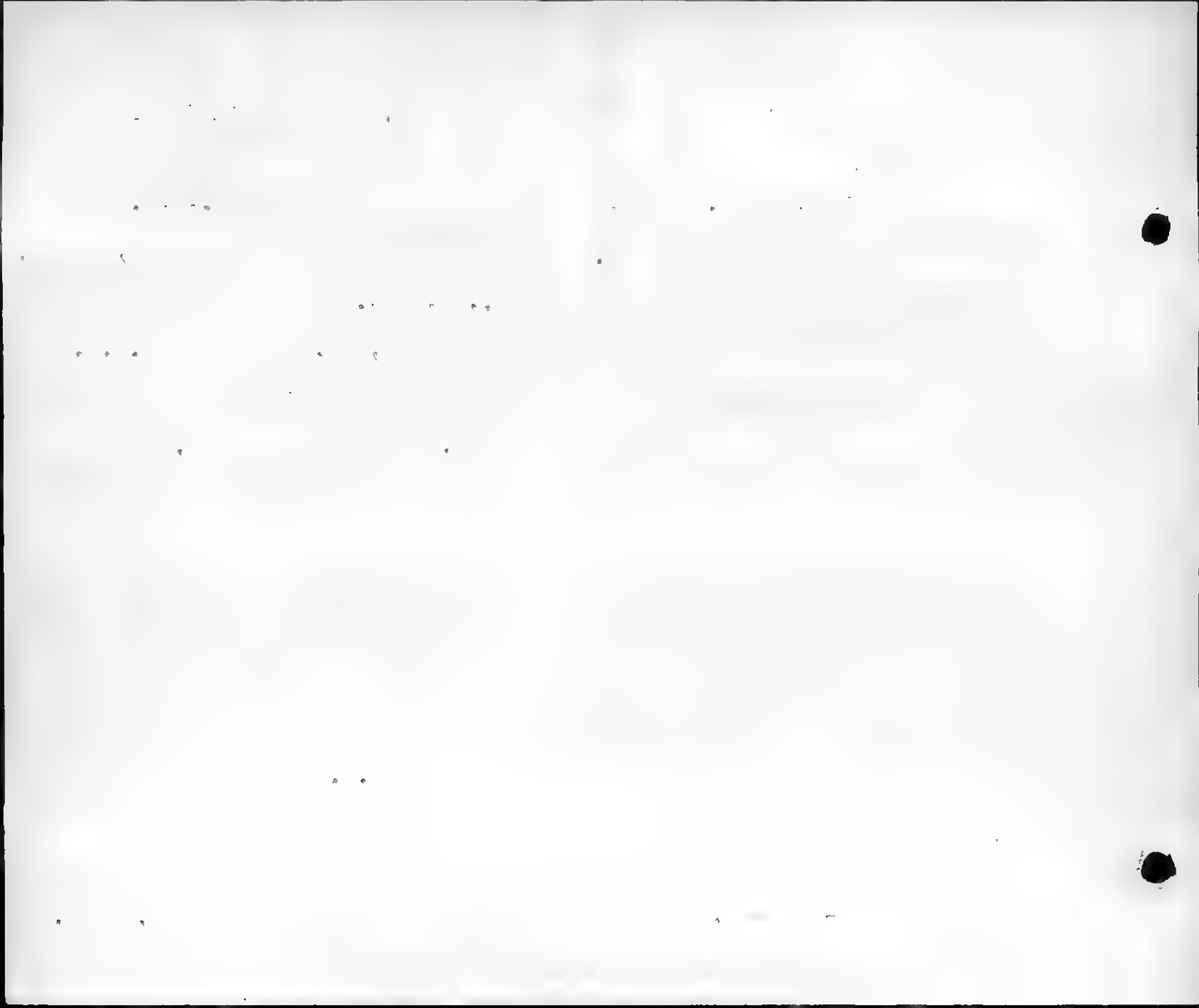
07686

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>1902 Snyder Ave. # 22.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>M.</b> Last <b>COSGROVE</b>				4. DATE OF DEATH Month <b>July</b> Day <b>17</b> Year <b>1960.</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept., 17, 1886.</b>	9. AGE (In years last birthday) <b>73</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Erie, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Casper Roman</b>				14. MOTHER'S MAIDEN NAME <b>Agnes Butler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		INFORMANT <b>Marie A. Pollhein</b>		Address <b>Same.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4-20-1</b> DUE TO <b>Constrictive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery</b> (c) <b>Myocardial Infarction</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>24 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-15</b> , 19 <b>60</b> , to <b>7-16</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>7-15</b> , 19 <b>60</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b> DATE SIGNED <b>7-18-60</b>							
ACTUAL SIGNATURE <b>JACK P. Pollins</b>		M.D. <b>BALTIMORE</b>					
PHYSICIAN'S NAME (Type) <b>JACK P. Pollins</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-20-60.</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>7225 Eastern Blvd., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Geller</b>				ADDRESS <b>6224 EASTERN AVE. BALTO., MD.</b>		24a. REC'D BY REGISTRAR <b>FUL 20 60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur J. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

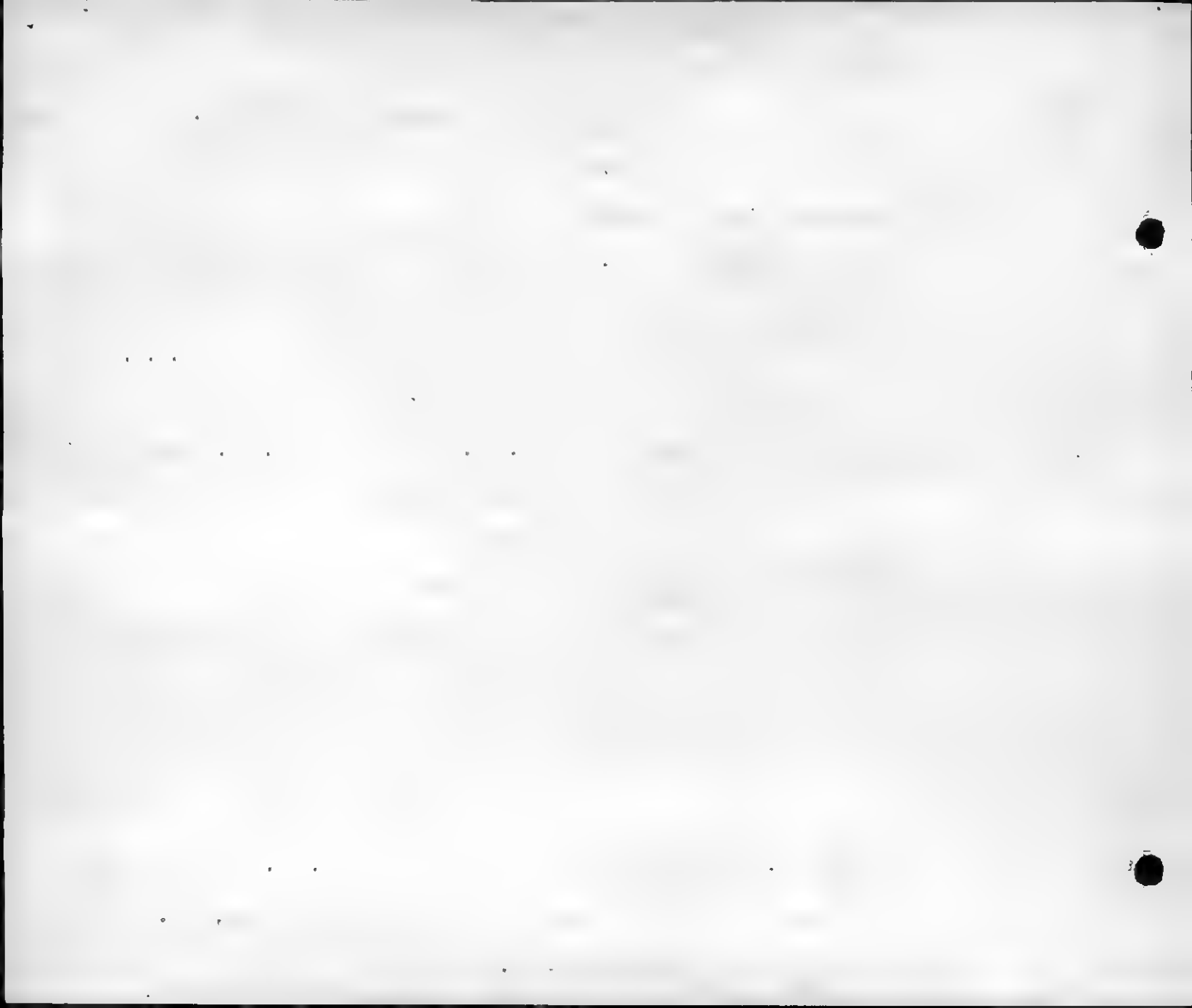
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7720

07687

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's County</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>			c. LENGTH OF STAY IN 1b <b>10 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mechanicsville</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LORENZO</b> Middle <b>D.</b> Last <b>CROUSE</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>1</b> Year <b>19 60</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>10/21/92</b>	9 AGE (In years last birthday) <b>67</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>		11. BIRTHPLACE (State or foreign country) <b>Saginaw, Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Clin. Rec. VAH, Balto 18, Md. Ft. Howard Division</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>HEART FAILURE (PULMONARY EDEMA)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>MYOCARDIAL INFARCTION</b> DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b> <b>1 MONTH</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>June 21</b> 19 <b>60</b> , to <b>July 1</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>July 1</b> 19 <b>60</b> , and that death occurred at <b>9:40 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>George C. McElPatrick</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <b>VAH, BALTO 18, MD. FT. HOWARD DIVISION</b>		22b. DATE SIGNED <b>7/2/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/5/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Morganza, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robinson Funeral Home, Leonardtown, Md.</b>				25a. REC'D BY REGISTRAR <b>JUL 7 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

MEDICAL CERTIFICATION



7721

CERTIFICATE OF DEATH

07688

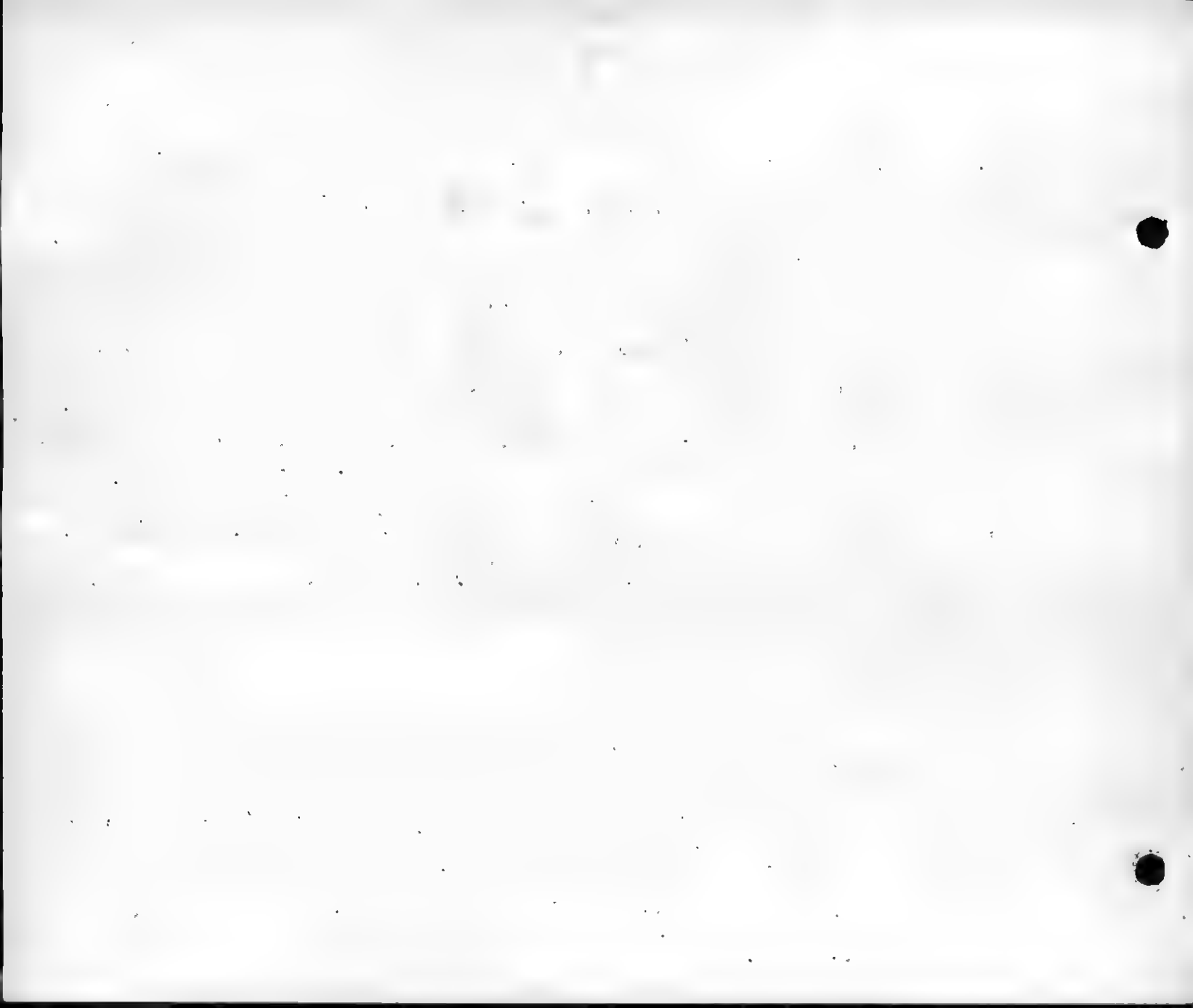
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Village Road</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Village Road, Baltimore 7</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1000 Woodford Road, Baltimore 7, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Philip</u> Middle <u>D'</u> Last <u>Adamo</u>		4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 11, 1902</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u> Hours <u>12</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D'Adamo Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Tronto, Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank D'Adamo</u>		14. MOTHER'S MAIDEN NAME <u>Anna Maria D'Adamo</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>012-20-4505</u>	
17. INFORMANT <u>Mrs. Mary C. D'Adamo</u>		Address <u>1000 Woodford Road, Baltimore 7, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u> <u>several yrs</u> <u>few years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u>July</u> Day <u>7</u> Year <u>1960</u> Hour <u>4:45</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>60</u> , to <u>July 7, 1960</u> that I last saw the deceased alive on <u>5 July</u> , 19 <u>60</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul H Royse</u>		ADDRESS (Street, city or town, state) <u>1403 Foley Lane 9 July 60</u>	
PHYSICIAN'S NAME (Type) <u>Paul H Royse</u>		DATE SIGNED <u>Pikeville 8, Md</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 11, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pikeville 8, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank J. Knecht</u>		24a. REC'D BY REGISTRAR <u>12 '60</u>	
ADDRESS <u>Pikeville 8, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Knecht</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
7722									
07689									
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>				
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>CATONSVILLE</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>306 N. ROLLING RD.</b>					d. STREET ADDRESS <b>306 N. ROLLING RD.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ADELA LOUISE DEFORD</b>					4. DATE OF DEATH Month Day Year <b>JULY 13, 1960</b>				
5. SEX <b>F.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 14, 1879</b>		9. AGE (In years last birthday) yrs <b>80</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>O.H.</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>HENRY KEIDEL</b>					14. MOTHER'S MAIDEN NAME <b>ADELA LAWRENCE</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>			16. SOCIAL SECURITY NO		17. INFORMANT Address <b>MR. LOUIS DEFORD, 306 N. ROLLING RD.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic C.V. Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Similarity</b>								INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 1954</b> to <b>July 13, 1960</b> , that (I) (we) last saw the deceased alive on <b>July 13, 1960</b> , and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>D.C. MacLaughlin</b>					M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>D.C. MacLaughlin, M. D.</b>					22d. ADDRESS <b>4508 Edmondson Village</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>7/15/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>			23d. LOCATION (City, town, or county) (State) <b>BALTO., MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WITZKE FUN. DIR. 4101 EDMONDSON AVE.</b>					25a. REC'D BY REGISTRAR DATE <b>JUL 15 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. Kraus</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 22 hours after death.

7723

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07690

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>16 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>Rt #16 Box 328</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>J</b> Last <b>De POITIERS</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>6</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 30 1886</b>
9. AGE (In years last birthday) <b>74 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PLUMBER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PLUMBING CO</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTO MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>GUSTAVE DePOITIERS</b>		14. MOTHER'S MAIDEN NAME <b>WALLY BESSER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>216-10-9755</b>	
17. INFORMANT <b>CLIN REC VAH BALTO MD FT HOWARD DIVISION</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>EDEMA OF LUNGS</b> <b>CARDIAC HYPERTROPHY AND DILATATION</b> <b>DIABETES MELLITUS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MARKED GENERALIZED ARTERIOSCLEROSIS</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <b>Status post surgical amputation both legs for arteriosclerotic obliterans</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JUNE 20</b> 19 <b>60</b> to <b>JULY 6</b> 19 <b>60</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>7/6/60</b> 19 <b>60</b> , and that death occurred at <b>2:35 PM</b> on the causes and on the date stated above			
22a. SIGNATURE <b>Thomas R Hood</b>		22b. DATE SIGNED <b>7/7/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>THOMAS R HOOD</b>		22d. ADDRESS <b>VAH BALTO 18 MD FT HOWARD DIVISION</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7-11-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight, Inc.</b>		25a. REC'D BY REGISTRAR <b>JUL 12 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			

Wm Cook-Blight Inc 6009 Harford Road



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

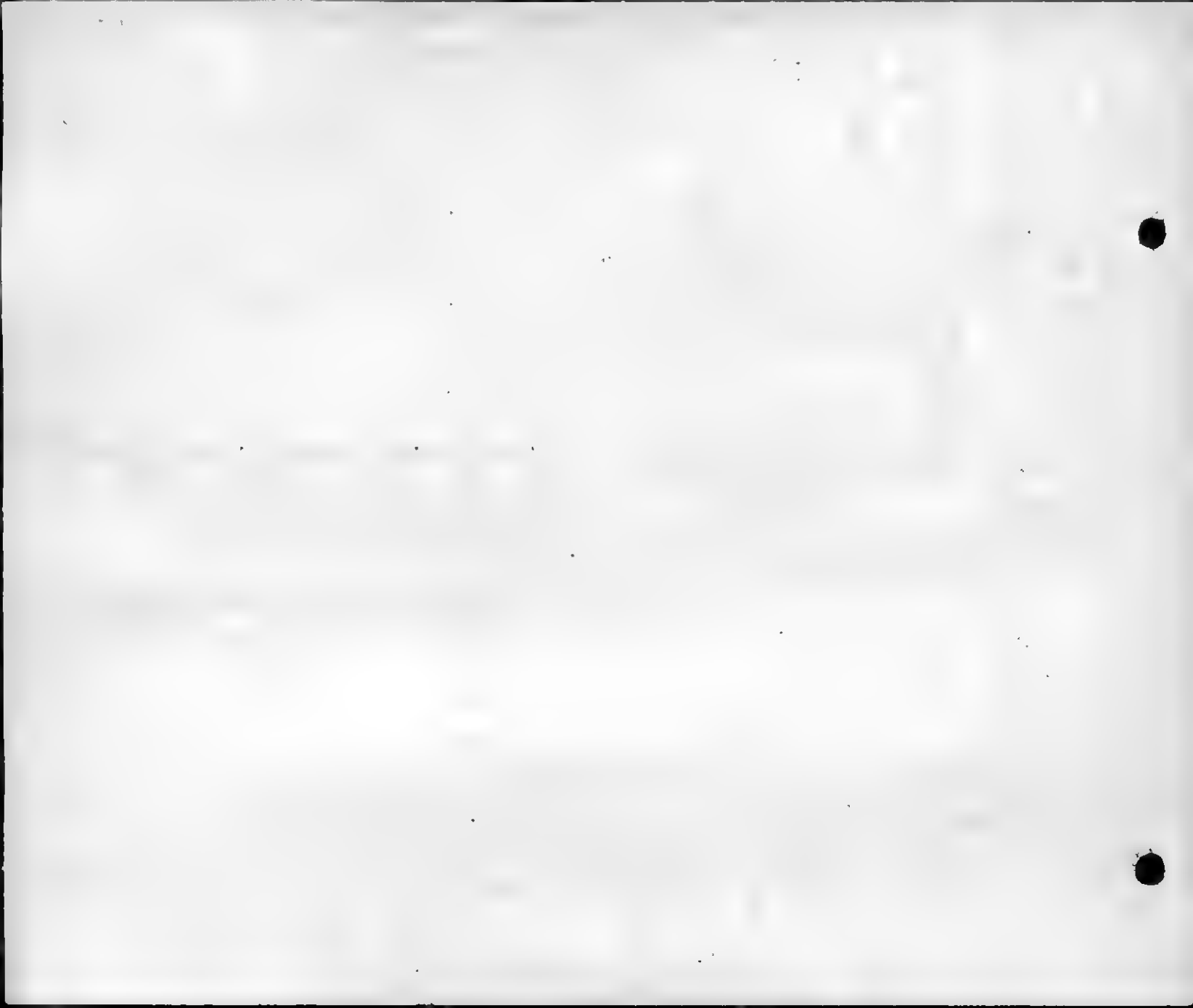
7724

CERTIFICATE OF DEATH

07692

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 18</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armcast Nursing Home</b>				d. STREET ADDRESS <b>2312 N. Charles Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>MAUDE</b> Middle <b>E.</b> Last <b>DRYDEN</b>		4. DATE OF DEATH Month <b>July</b> Day <b>30</b> Year <b>19 60</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 8, 1876</b>	9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work'g life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>White Hall, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Thomas Elliott</b>				14. MOTHER'S MAIDEN NAME <b>Sallie Wilson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address <b>Mr. Thomas E. Dryden-2312 N. Charles Street #18</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart congestive heart failure</b> 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease.</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of hip (right) 6/2/60</b>							19. WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 16, 1960</b> to <b>July 30, 1960</b> that I last saw the deceased alive on <b>July 30, 1960</b> , and that death occurred at <b>6:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>F. M. TUGAN</b>				ADDRESS (Street, city or town, state) <b>15 E. BIDDLEST BALTIMORE MD</b> DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>F. M. TUGAN MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/2/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. [Signature]</b> ADDRESS <b>17, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 3 '60</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

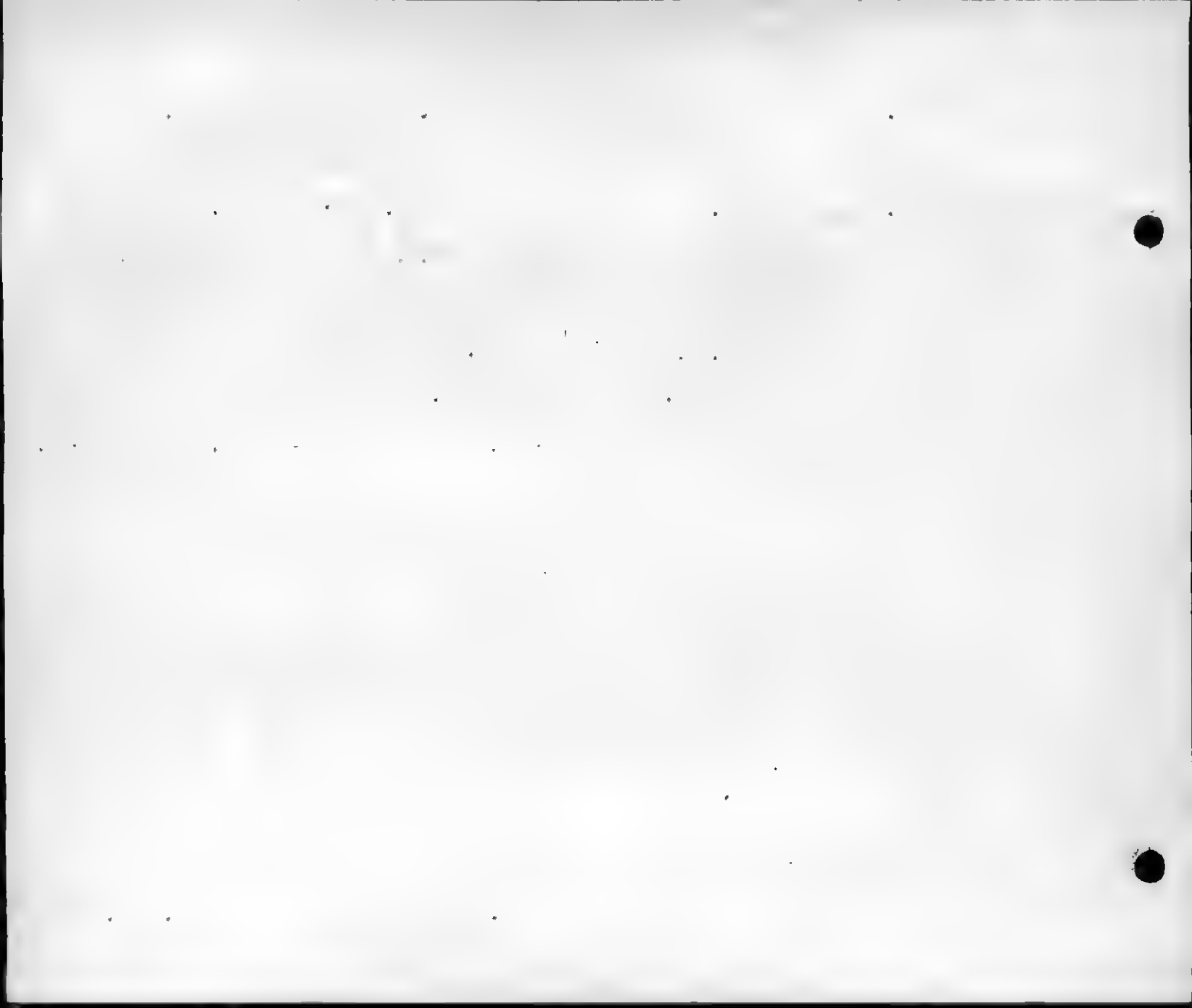
VR AIS (4)  
ISM 9/59

7725

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

07693

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>201 N. Beechwood Ave.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>201 N. Beechwood Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>MILTON</b> Last <b>EARECKSON, Jr.</b>		4. DATE OF DEATH Month <b>July</b> Day <b>11</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 7, 1898</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR: Months <b>6</b> Days <b>4</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clergyman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bishop Cummins' R. E. Church</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Milton Eareckson, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Anna M. Cacy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. L. Ruth Eareckson - 201 N. Beechwood Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cedene carcinoma of sigmoid colon c</b> DUE TO (b) <b>metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>June 1952</b> to <b>July 11, 1960</b> , that (I) (we) last saw the deceased alive on <b>7/9/60</b> , and that death occurred at <b>4:20 P.M.</b> from the causes and on the date stated above. 22a. SIGNATURE <b>LESTER A. WALLACE</b> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <b>LESTER A. WALLACE</b> 22d. ADDRESS <b>1039 St Paul St</b> 22e. DATE SIGNED <b>7/12/60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/14/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner &amp; Sons - Balto 17th</b>		25a. REC'D BY REGISTRAR <b>JUL 13 '60</b> 25b. REGISTRAR'S SIGNATURE <b>Chas. E. Kiser</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 11/59

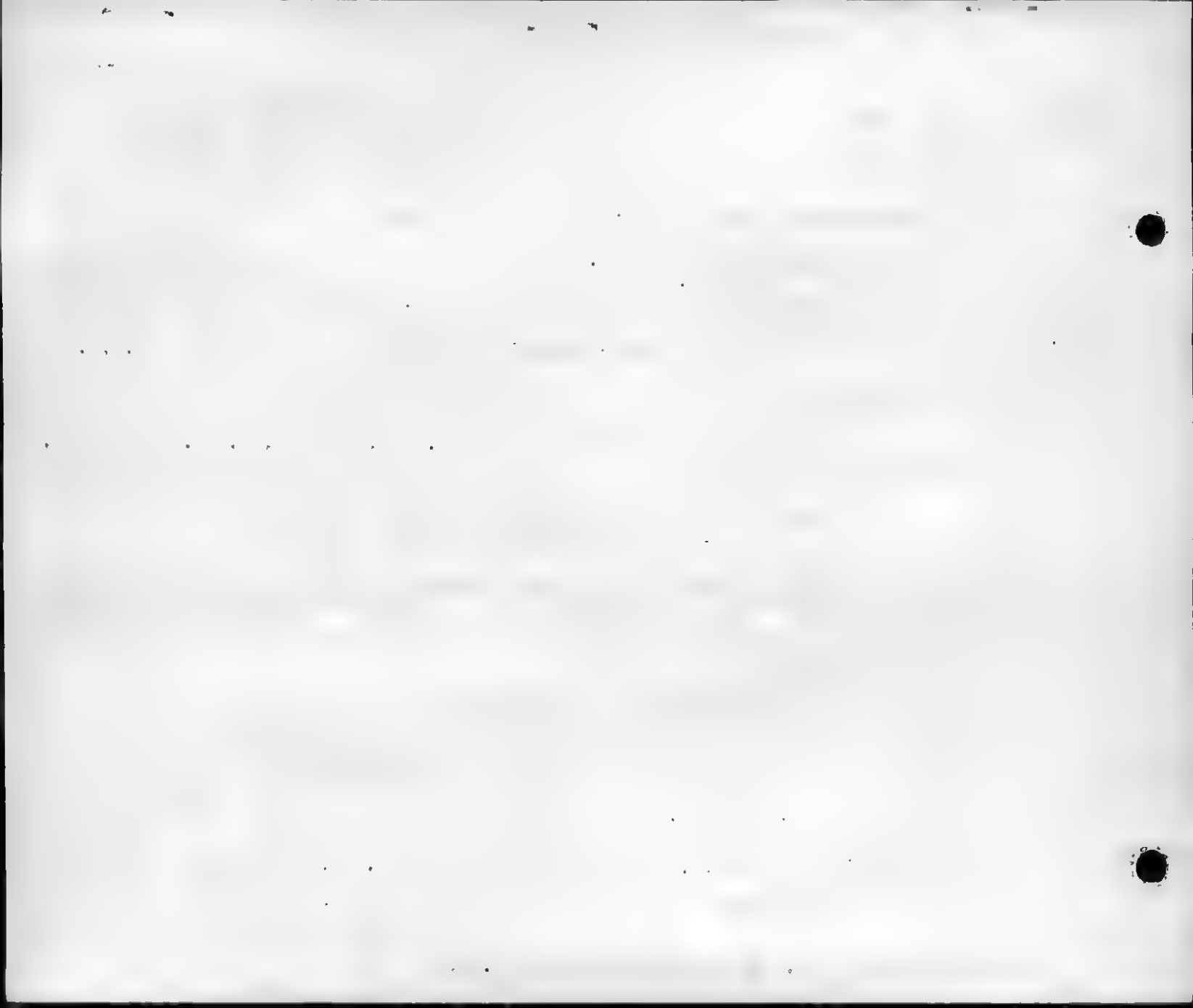
7726

9

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07694

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>189 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
				d. STREET ADDRESS <b>1450 LANGFORD ROAD</b>			
				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>ARTHUR R. EIDEMILLER</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>1</b> Year <b>19 60</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 24, 1898</b>		9 AGE (In years lost birthday) <b>62</b> yrs.	IF UNDER 1 YEAR: Months <b></b> Days <b></b>	IF UNDER 24 HRS: Hours <b></b> Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction Analyst</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Peter Eidemiller</b>				14. MOTHER'S MAIDEN NAME <b>Louise Snyder</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>213 28 1167</b>		17. INFORMANT Address <b>Clinical Rec. VAH, Balto 18, Md. Ft. Howard Div.</b>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>EDEMA OF THE LUNGS</b>							<b>UNKNOWN</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>OLD CEREBRAL INFARCTION RIGHT</b>							<b>UNKNOWN</b>
(c) <b>MARKED GENERALIZED ARTERIOSCLEROSIS</b>							<b>UNKNOWN</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)			
21 I certify that (x) (this hospital) attended the deceased from <b>December 14, 1959</b> to <b>July 1, 1960</b> , that (x) (we) last saw the deceased alive on <b>July 1, 1960</b> , and that death occurred at <b>1:50pm</b> from the causes and on the date stated above							
22a. SIGNATURE <b>Charles Allen</b>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b DATE SIGNED <b>7/1/60</b>	
22c PHYSICIAN'S NAME (Type) <b>CHARLES ALLEN, M.D.</b>				22d ADDRESS <b>VAH, BALTO. MD. - FT HOWARD DIVISION</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b DATE THEREOF <b>July 4/60</b>		23c NAME OF CEMETERY OR CREMATORY <b>Allegheny Memorial Cemetery</b>		23d LOCATION (City, town, or county) (State) <b>Pittsburgh, Pennsylvania</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Witke Funeral Dir.</b>				25a REC'D BY REGISTRAR <b>JUL 5 '60</b>		25b REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	
ADDRESS <b>4101 Edmondson Ave, Balto, Md.</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The attending physician and complies filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7679

## CERTIFICATE OF DEATH

Reg. Dist. No.

07695

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Kent</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>			
c. LENGTH OF STAY IN 1b <u>1 1/2 Months</u>				d. STREET ADDRESS <u>None</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Queen</u> Last <u>Elbourn</u>				4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/21/1896</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>							
13. FATHER'S NAME <u>Joseph Leonard Elbourn</u>				14. MOTHER'S MAIDEN NAME <u>Harriot Beck</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>218-16-6481</u>		17. INFORMANT <u>MYRA THARP (Daughter)</u> Address <u>BALTO.-MD. 4801 ELDON GREEN</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Feb 23, 1960</u> , to <u>July 21, 1960</u> , that I last saw the deceased alive on <u>July 21, 1960</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Abram Goldman</u> M.D.				ADDRESS (Street, city or town, state) <u>3322 FREDERICK AV. BALTO.-29, MD.</u>			
DATE SIGNED <u>7/22/60</u>							
PHYSICIAN'S NAME (Type) <u>ABRAM GOLDMAN, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-24-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Rock Hall MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>				ADDRESS <u>Church Hill MD</u>		24a. REC'D BY REGISTRAR <u>JUL 26 60</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles L. Farns</u>							



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

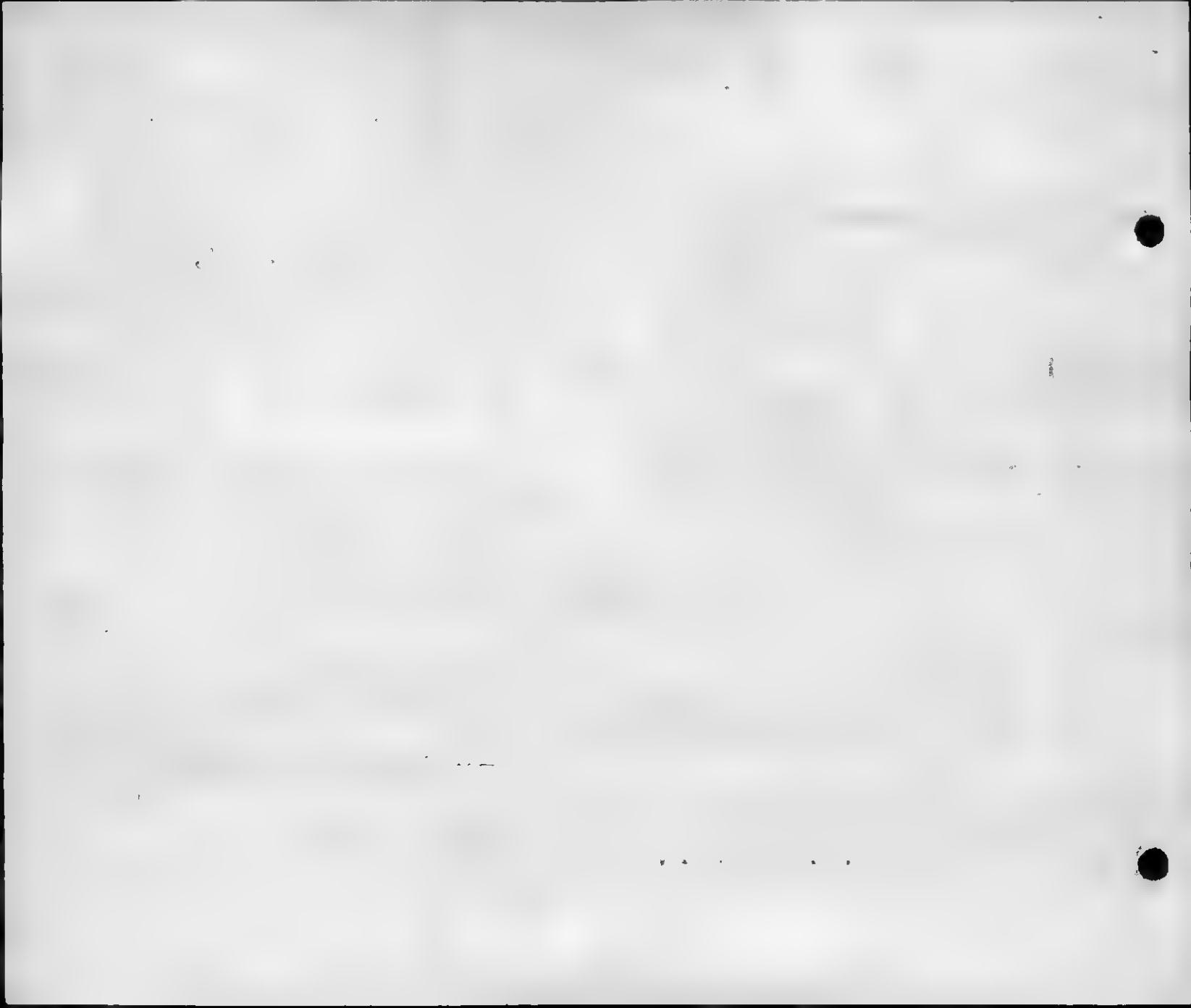
# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07696

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		Item 9 Film G-67 7/27/60. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN b. <b>14 yrs</b>		USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		d. STREET ADDRESS <b>2 Tanglewood Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>KENNETH EVANS</b>		4. DATE OF DEATH <b>July 6, 19 60</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-14-16</b>		9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours M'n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fountain Syrup</b>		11. BIRTHPLACE (State or foreign country) <b>WALES</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William Evans</b>		14. MOTHER'S MAIDEN NAME <b>MARY ANNE DYKE</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>YES WWII</b>		16. SOCIAL SECURITY NO. <b>14-03-5466</b>	
17. INFORMANT <b>ELLEN EVANS</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>7/7/60</b>		ACTUAL SIGNATURE <b>Wm. V. Lovitt</b>	
EXAMINER'S NAME (Type) <b>Wm. V. Lovitt, M.D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-11-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEM.</b>		22d. LOCATION (City, town, or country) (State) <b>BALTO MD</b>		23. FUNERAL DIRECTOR <b>C. F. EVANS &amp; SON</b>		24a. REC'D BY REGISTRAR <b>MIL 11 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hines</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

7728

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07697

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Baltimore</b>			
c. LENGTH OF STAY IN lb <b>55 Days</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>829 Patapsco Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>M.</b> Last <b>FAGAN</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>4</b> Year <b>1960</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 30, 1899</b>		9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR: Months <b></b> Days <b></b> Hours <b></b> Min. <b></b> IF UNDER 24 HRS: Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Fagan</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Jane Hainsey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWII</b>		16. SOCIAL SECURITY NO. <b>209-01-5266</b>		17 INFORMANT <b>Clin. Records, Vet. Adm Hosp Balto. Md. Ft. Howard Div</b> Address <b></b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EDEMA OF THE LUNGS</b> <b>5-22X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>2. CARCINOMA OF THE PROSTATE WITH METASTASIS TO BONE, LIVER AND RIGHT LUNG</b> (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>1 1/2 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that <b>PHILIP J. JENSEN</b> (this hospital) attended the deceased from <b>July 10, 1960</b> to <b>July 14, 1960</b> (we) last saw the deceased alive on <b>July 4, 1960</b> , and that death occurred at <b>10:15 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Philip J. Jensen</b> M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>7/14/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>PHILIP J. JENSEN, M.D.</b>				22d. ADDRESS <b>VAH, BALTO. D.D. FT. HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>7-6-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Grandview Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Altoona, Pennsylvania</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Am-Cook Bli-ht Inc. 6009 Harford Rd. Balto. Md.</b>				25a. REC'D BY REG STRAR DATE <b>JUL 8 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneale</b>	

Handwritten signature/initials at the bottom of the page.



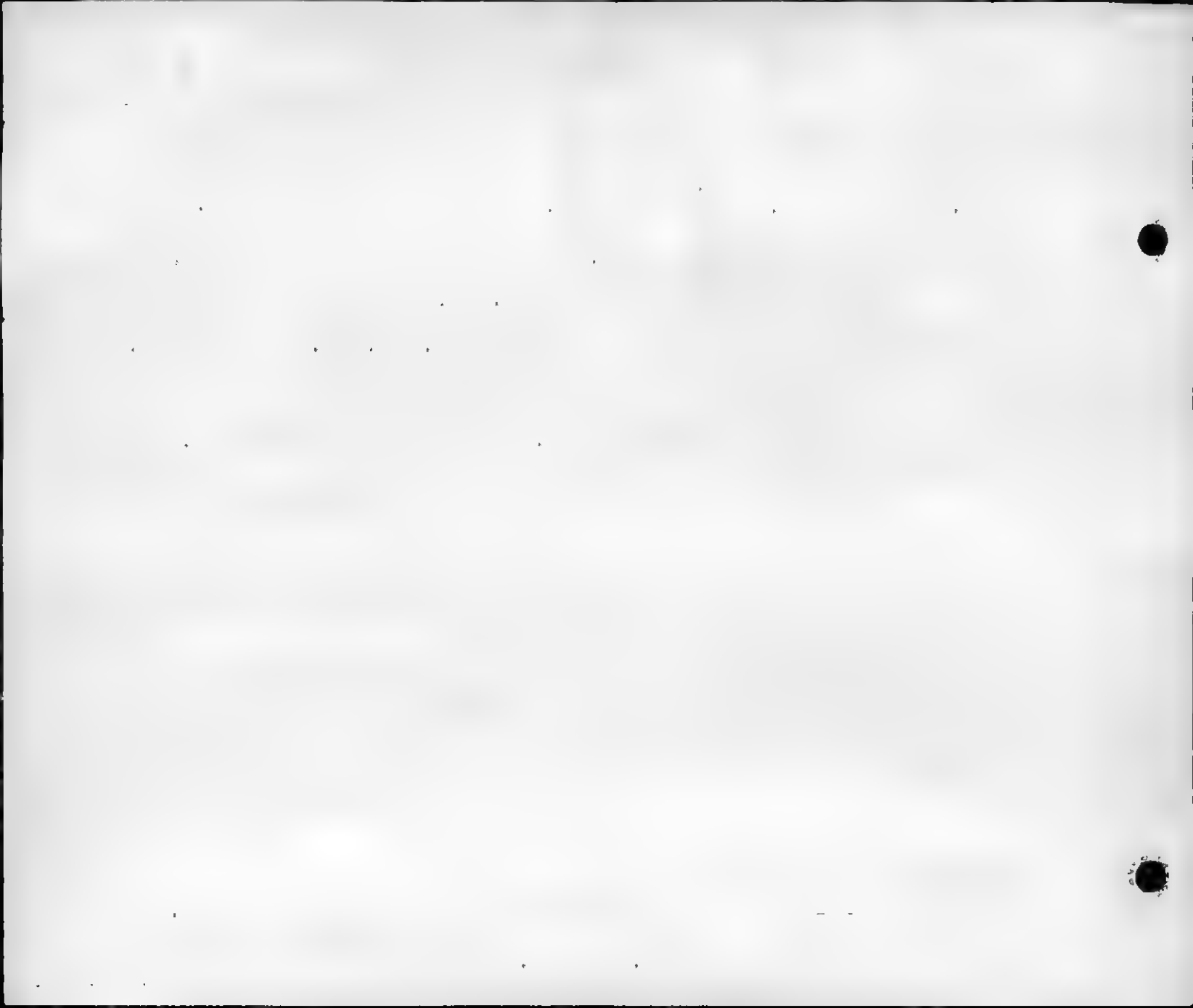
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7729

## CERTIFICATE OF DEATH

Reg. Dist. No. 07698

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. LENGTH OF STAY IN 1b <b>8 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Res. Eastern Ave. &amp; Birdwood Rds</b>		e. STREET ADDRESS <b>Box 50 Rt 14, 20, Md.</b>	
3. NAME OF DECEASED (Type or print) First <b>Carrie</b> Middle <b>R.</b> Last <b>Fickus</b>		4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 26, 1876</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Balto. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Koester</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes name unknown) <b>No</b> (If yes, give year or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Julia Debelius Eastern &amp; Birdwood Rd</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cancer of stomach &amp; M. L. L.</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>3 m 6 h</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 19 30</b> to <b>July 28</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>July 21</b> , 19 <b>60</b> , and that death occurred at <b>6 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Box 50 Rt 14, 20, Md.</b> DATE SIGNED <b>7/29/60</b> ACTUAL SIGNATURE <b>Robert J. Lyden M.D.</b> PHYSICIAN'S NAME (Type) <b>ROBERT J. LYDEN M.D.</b>			
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-1-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		22d. LOCATION (City, town, or county) (State) <b>Eastern Ave. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda 7922 Wise Ave. 22, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 2 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6 Filed 7/14/60 1wk

07699

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>		c. LENGTH OF STAY IN TB <u>LT</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1401 HARFORD RD</u>		e. STREET ADDRESS <u>1401 HARFORD RD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ANN FINNEY</u>		4. DATE OF DEATH Month Day Year <u>July 5 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John V Keeney</u>		14. MOTHER'S MAIDEN NAME <u>SARAL C MILLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>ADA N Cleveland</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> DUE TO <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>associated secondary anemia</u> DUE TO <u>—</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular disease; malnutrition</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If other, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1947</u> to <u>July 5, 1960</u> , that I last saw the deceased alive on <u>July 3, 1960</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H.V. Harbold</u> M.D.		ADDRESS (Street, city or town, state) <u>4706 Harford Road</u> DATE SIGNED <u>7/6/60</u>	
PHYSICIAN'S NAME (Type) <u>H.V. HARBOLD M.D.</u>		<u>Baltimore-14 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-8-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD LEM</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Co. MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.F. EVANS &amp; SON</u> ADDRESS <u>8802 HARTFORD RD</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 11 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7730

## CERTIFICATE OF DEATH

Reg. Dist. No. 07700

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Ellicott City</b>				c. LENGTH OF STAY IN 1b <b>65 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>River Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANCIS JOSEPH FISHER</b>				4. DATE OF DEATH Month Day Year <b>July 4th., 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 14, 1894</b>	
9. AGE (In years lost birthday) <b>65 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Frank A. Fisher</b>				14. MOTHER'S MAIDEN NAME <b>Mary M. Miller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-34-3025</b>		17. INFORMANT Address <b>Mrs. Mary E. Fisher River Rd. Ellicott City, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, Fundus of Stomach</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-1</b> , 19 <b>57</b> to <b>7-4</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>7-4</b> , 19 <b>60</b> , and that death occurred at <b>1:40</b> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George E. Burtorf</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>41 CHURCH ST 7-6-60</b>			
PHYSICIAN'S NAME (Type) <b>GEORGE E. BURTORF</b>				<b>ELlicott City, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 7, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Sons</b>				ADDRESS <b>Catonsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 7 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

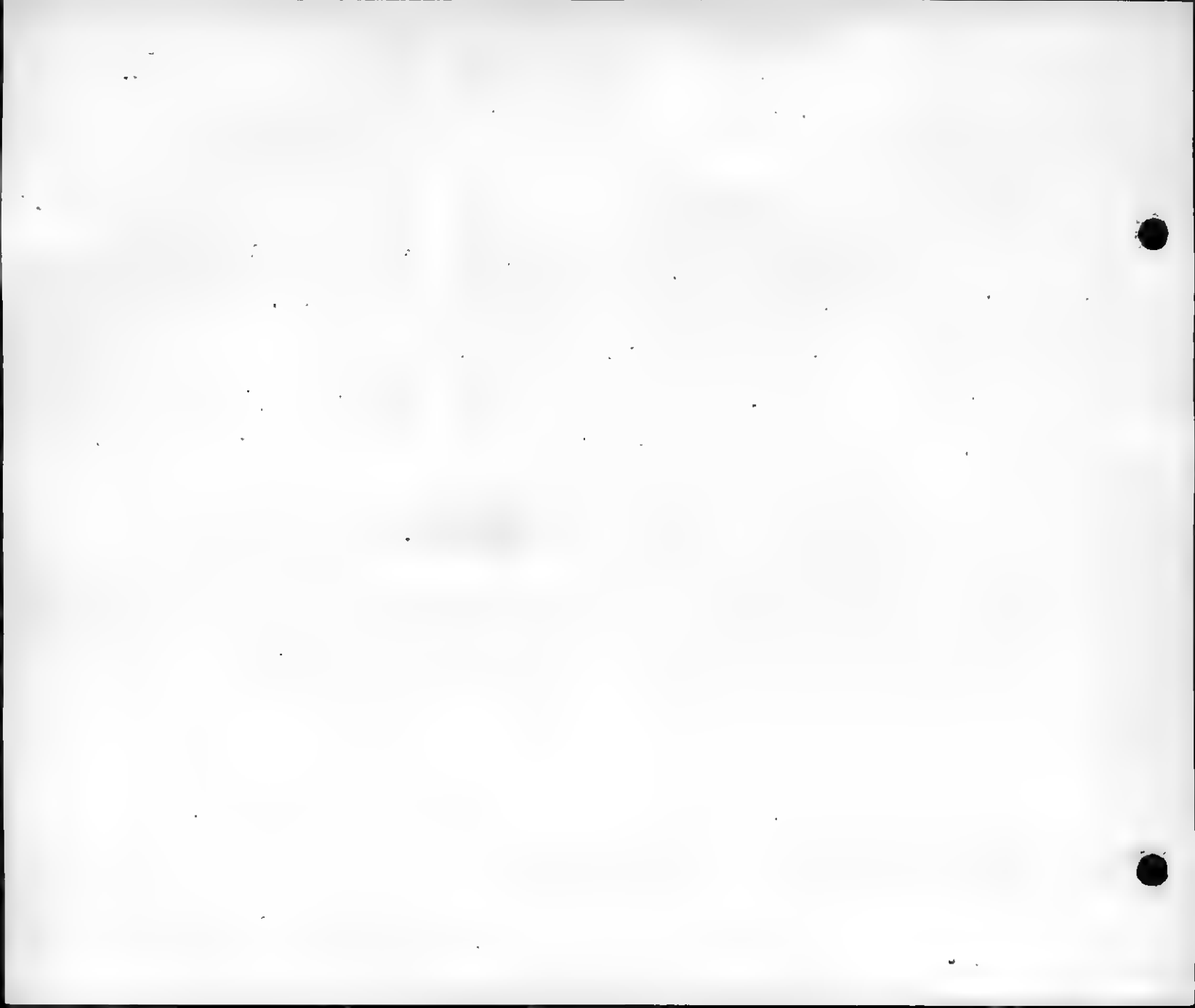
7731

## CERTIFICATE OF DEATH

07701  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROSEDALE</b>				c. LENGTH OF STAY IN lb <b>LIFE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6534 CORKLEY AVE.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES RICHARD FISHER Sr</b>				4. DATE OF DEATH Month Day Year <b>JULY 26 1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV 14 1911</b>	
9. AGE (In years last birthday) <b>48</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DELIVERY MAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HUTZLERS</b>			
13. FATHER'S NAME <b>William Fisher</b>				14. MOTHER'S MAIDEN NAME <b>Rose Marie Digens</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <b>NO</b>				16. SOCIAL SECURITY NO. <b>215-07-2672</b>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Coma</b> DUE TO <b>Saenec's <del>Chronic</del> Cirrhosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 2, 1960</b> to <b>July 26, 1960</b> , that I last saw the deceased alive on <b>July 26, 1960</b> , and that death occurred at <b>2:00 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John L. Smith, M.D.</b>				DATE SIGNED <b>8019 Philadelphia Road</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>July 29, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>HOLT REDEEMER</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO, CITY MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sosseh Funeral Home</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 27 '60</b>			
ADDRESS <b>7401 Belair Rd #6</b>				24b. REGISTRAR'S SIGNATURE <b>Chas. L. Harris</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07702

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) <input checked="" type="checkbox"/> a. STATE <u>Maryland</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN TB _____		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fisher Road</u>				d. STREET ADDRESS <u>4303 Glenmore Avenue</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mr. Bayard Taylor Fleming</u>				<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>18th</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1885</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Parker Metal Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>New Castle, Delaware</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>		16. SOCIAL SECURITY NO. <u>215-07-0155</u>		17. INFORMANT Address <u>Mrs. Isabelle B. Fleming</u> <u>same</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> DUE TO <u>Coronary Circulation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>?</u> DUE TO <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour _____ o. m. _____ p. m. _____ 19____	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack P. Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>JACK P. COLLINS</u>		7-1860					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Leonard J. Ruck 5305 Harford Road #14</u>					
24a. REC'D BY REGISTRAR <u>DATE JUL 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>					

TO BE FILED IN MEDICAL EXAMINER'S OFFICE: This certificate should be executed within 24 hours after death. If any other certificate is necessary, please execute a separate certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7732

## CERTIFICATE OF DEATH

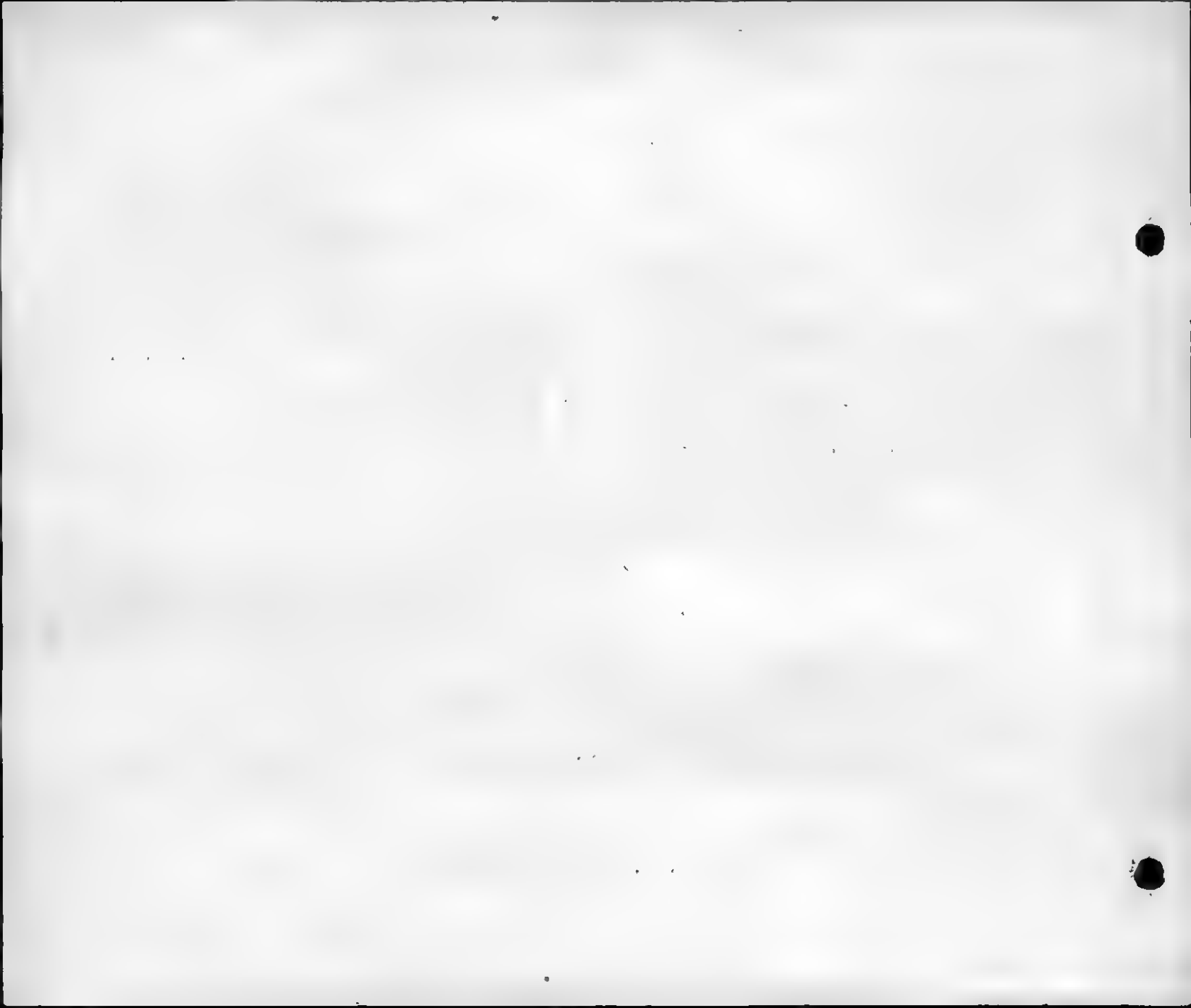
07703

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>Byr 4mth 28dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
f. STREET ADDRESS <b>3378 North Avenue</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Edward Anthony Foley</b>		4. DATE OF DEATH Month Day Year <b>July 5 19 60</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 17, 1912</b>
9. AGE (In years last birthday) yrs <b>47</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Patrick G. Foley</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Schrota</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>110th fld, art. 1934?</b>		16. SOCIAL SECURITY NO. <b>213-05-5060</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 7, 19 52, to July 5, 19 60</b> , that I last saw the deceased alive on <b>July 5, 19 60</b> , and that death occurred at <b>6:30 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 7-5-60</b>			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		M. D. <b>SPRING GROVE STATE HOSPITAL</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/14/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Catharine</b>	22d. LOCATION (City, town, or county) (State) <b>4300 Old Zimmed Rd</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. J. Talarone</b>		ADDRESS <b>1318 Light St</b>	
24a. REC'D BY REGISTRAR <b>Jul 14 1960</b>		24b. REGISTRAR'S SIGNATURE <b>Walter L. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: That the death certificate is executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

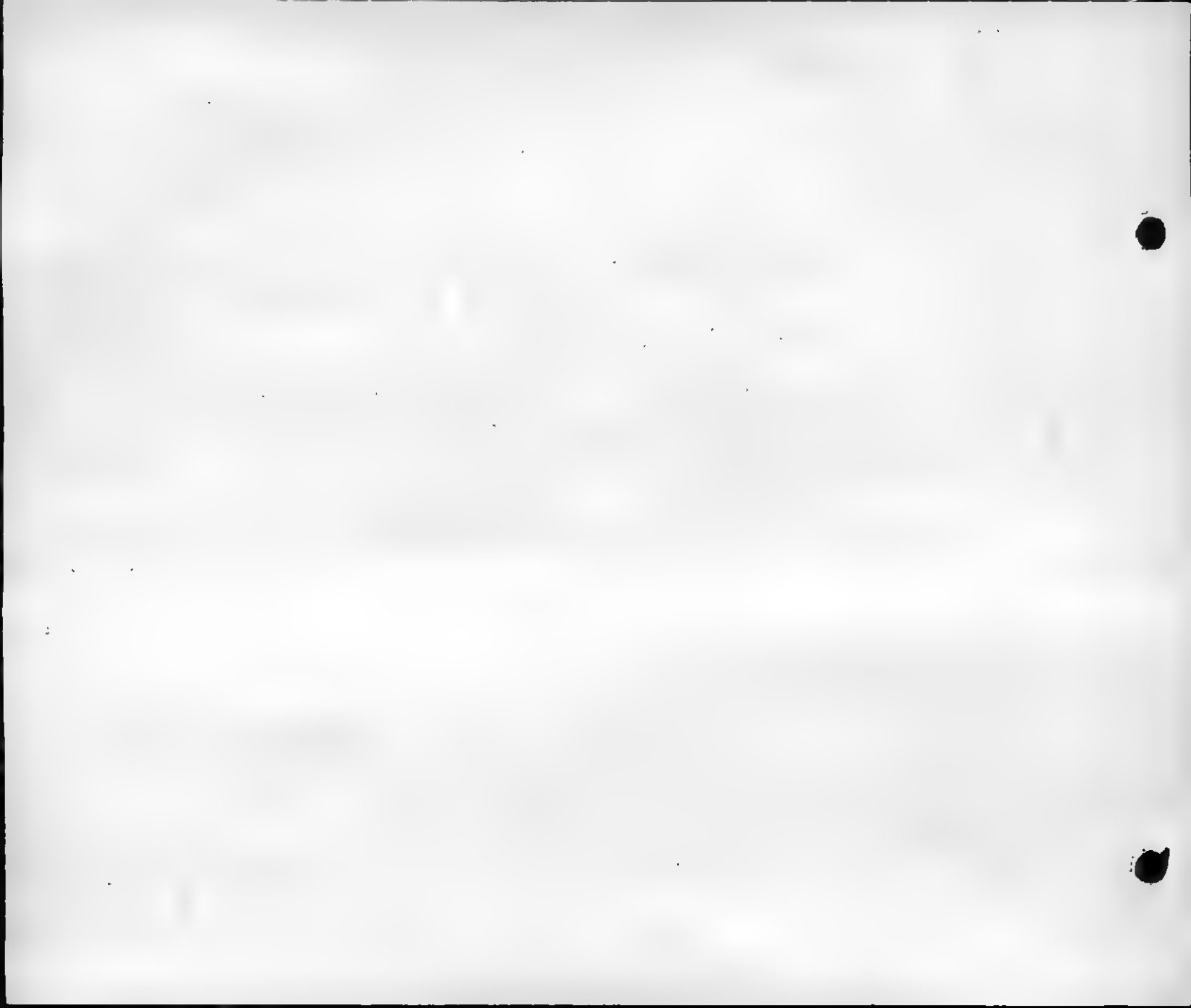
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

(5)

7680

07704

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>			
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>4300 Wilkins Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Eleanora Fox</u>				4. DATE OF DEATH <u>July 17 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 16, 1875</u>	
9. AGE (In years last birthday) <u>85</u> yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk Emerson Heritage</u>				11. BIRTHPLACE (State or foreign country) <u>MD</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>F.W. Fox</u>				14. MOTHER'S MAIDEN NAME <u>Lucinda Watkins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown, If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-05-0194</u>			
17. INFORMANT <u>Mrs. David Updegraff Wilkins</u>				Address <u>4200 Wilkins Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Edema of lungs</u> <u>421.4</u> DUE TO (b) <u>Ch. Valvular heart disease</u> Conditions if any, which gave rise to immediate cause (a) stating the underlying cause lost (c) <u>Arterio-sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>3 yrs.</u> <u>10 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>July 17 1960</u> , that (I) (we) last saw the deceased alive on <u>July 17 1960</u> , and that death occurred on <u>July 17 1960</u> at <u>8:15 P.M.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Geo. E. Wells</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Geo. E. Wells</u>				22d. ADDRESS <u>4100 Edmondson Ave. - Balto 29</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>7/20/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Pk Balto. 7, Md</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wittke F.W.</u> ADDRESS <u>4101 Edmondson Ave</u>				25a. REC'D BY REG. STRAR DATE <u>JUL 21 60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7733

## CERTIFICATE OF DEATH

Reg. Dist. No. 07705

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt 16 Box 49 Balto, 20</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ruby N. Frank</u>		4. DATE OF DEATH Month Day Year <u>July 25 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-5-1898</u>
9. AGE (In years last birthday) yrs. <u>61</u>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housew. for</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Hanford Co. Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Benjamin Cadle</u>	
14. MOTHER'S MAIDEN NAME <u>Alice Strong.</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>220-01-0752</u>		INFORMANT Address <u>Walter R Frank Rt 16 Box 49 Balto 20.</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, Generalized</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASHD + Cerebral Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			
18. INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1956</u> to <u>July 25 1960</u> , that I last saw the deceased alive on <u>July 25 1960</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert J. Lyden</u> M.D.		DATE SIGNED <u>July 21, 1960</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT J. LYDEN, M.D.</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-29-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Belair Memorial Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Belair Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Larsen Family Home 7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 27 '60</u>	24b. REGISTRAR'S SIGNATURE <u>William L. Frank</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

7734

07706

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>2mth8days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. STREET ADDRESS <b>606 Brookwood Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Louisa</b> Middle <b>M.</b> Last <b>Friese</b>				4. DATE OF DEATH Month <b>July</b> Day <b>23</b> Year <b>1960</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1877, July 3, 83</b>		9. AGE (In years last birthday) <b>22</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>1</b> Days <b>23</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>weeks</b> <b>years</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Baltimore, Md</b>		
20f. (City or town) <b>Baltimore, Md</b>			20g. (County) <b>Baltimore</b>			20h. (State) <b>Md</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>May 13</b> , 19 <b>60</b> , to <b>July 23</b> , 19 <b>60</b> . That (I) (we) last saw the deceased alive on <b>July 23</b> , 19 <b>60</b> , and that death occurred at <b>11A</b> AM, from the causes and on the date stated above.							
22a. SIGNATURE <b>Loretta Y. F. Hsu</b>				22b. DATE SIGNED <b>July 23, 1960</b>		22c. PHYSICIAN'S NAME (Type) <b>LORETTA Y. F. HSU</b>	
22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL</b>				22e. ADDRESS <b>Catonsville 28, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/26/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke F.D. 4101 Edmondson Ave.</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 26 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kiser</b>	

Page 1

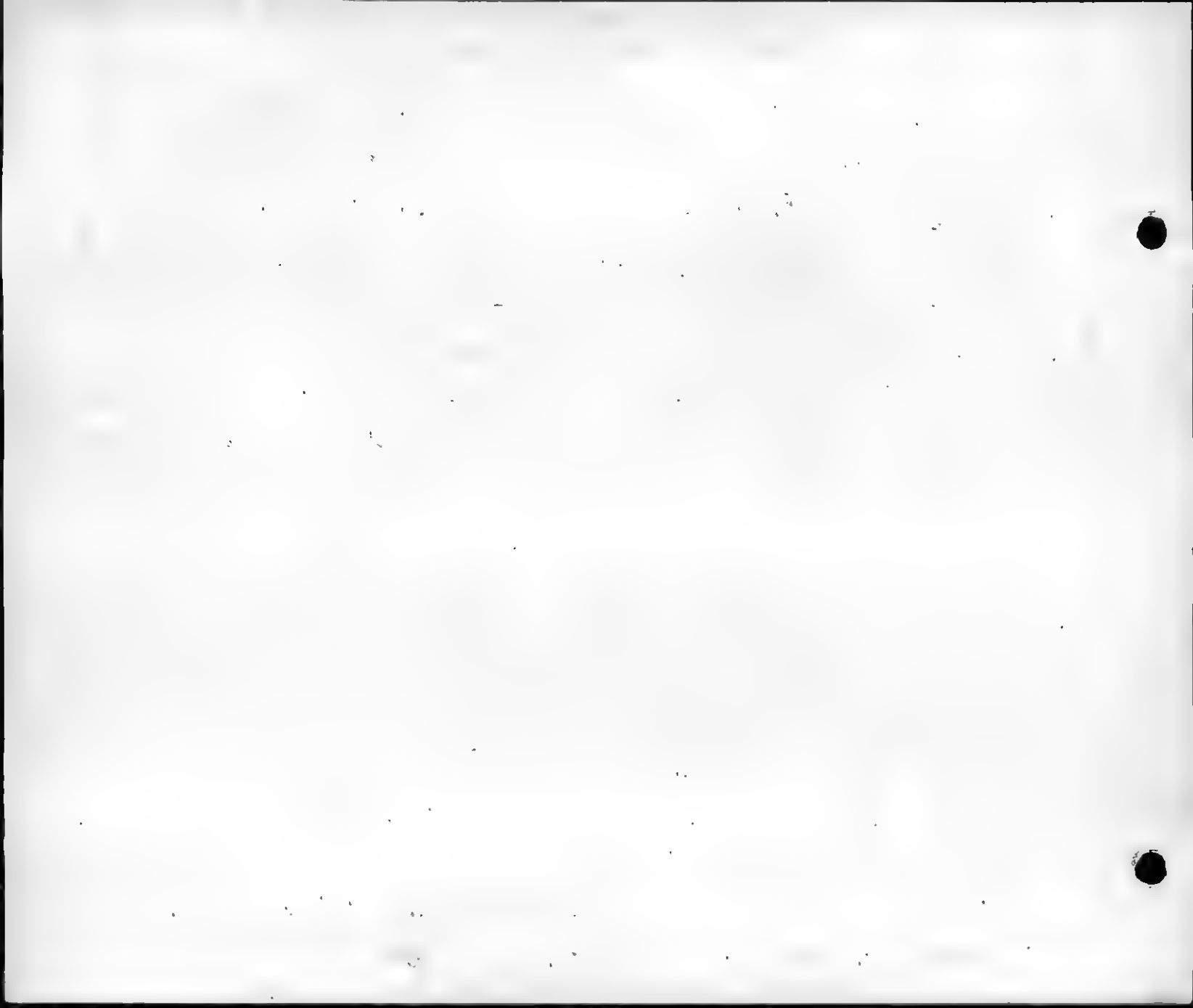
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7688

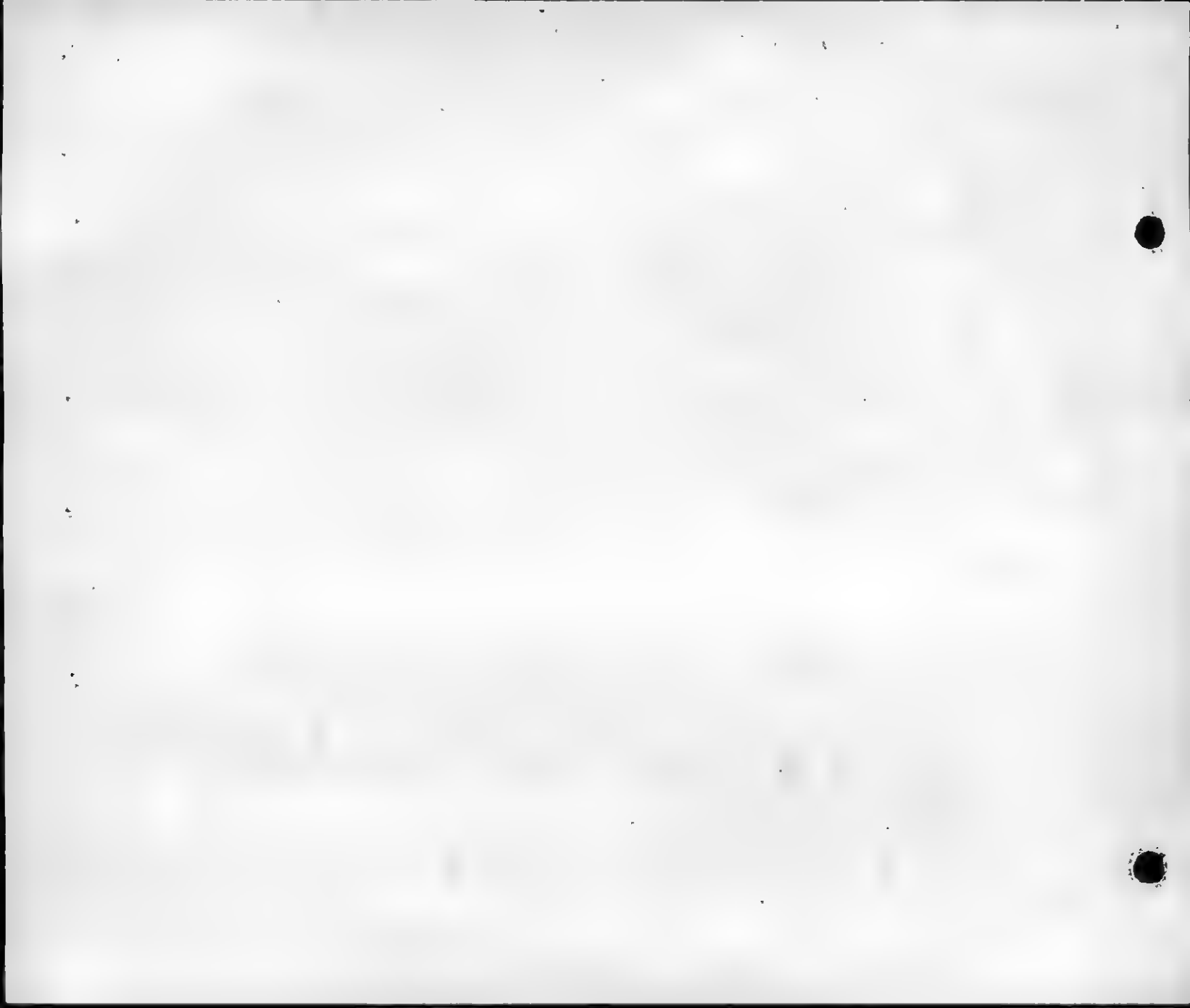
## CERTIFICATE OF DEATH

Reg. Dist. No. 07207

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Carney</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3207 E. Joppa Road</i>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Carney</i> d. STREET ADDRESS <i>3207 E. Joppa Rd.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <i>Rosie</i> Middle <i>Lee</i> Last <i>Fuller</i>		4. DATE OF DEATH Month <i>July</i> Day <i>4</i> Year <i>19 60</i>	
5 SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>9-16-1875</i>
9 AGE (In years last birthday) <i>84</i> yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <i>Maryland</i>		12 CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Henry Penn Dent</i>		14. MOTHER'S MAIDEN NAME <i>Amanda Shanklin</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Howard Fuller</i> Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Degenerative heart disease</i> <i>4-22-2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>old age.</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home farm factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1940</i> , to <i>July 4, 1960</i> , that I last saw the deceased alive on <i>July 3, 1960</i> , and that death occurred at <i>2:15 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Harold H Burns</i> M.D.		ADDRESS (Street, city or town, state) <i>8106 Harford Rd</i> DATE SIGNED <i>7-6-60</i>	
PHYSICIAN'S NAME (Type) <i>Harold-H. Burns</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>7/7/1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Hiss Methodist Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Rd.</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 11 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

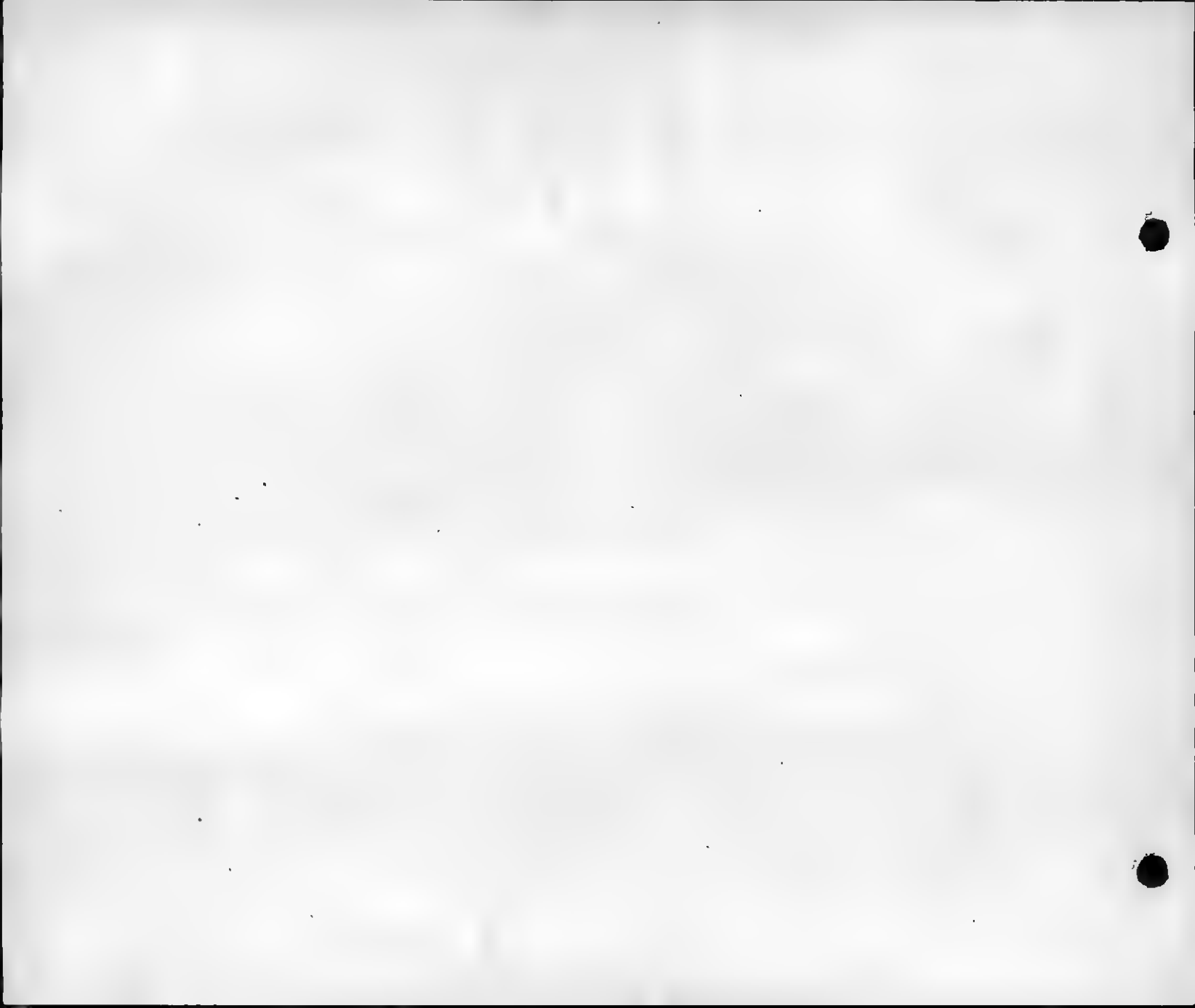


<div style="display: flex; justify-content: space-between;"> <div> <p>7735</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</p> </div> <div> <p>77708</p> <p>CERTIFICATE OF DEATH</p> </div> </div>									
<b>1 PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> <u>MARYLAND</u>					<b>2 USUAL RESIDENCE</b> (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY _____				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			c. LENGTH OF STAY IN 1b <u>60 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5806 EDMONDSON AVE</u>					d. STREET ADDRESS <u>5806 EDMONDSON AVE</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>ROSA</u> First <u>E.</u> Middle <u>GANTT</u> Last					<b>4. DATE OF DEATH</b> <u>JULY</u> Month <u>13</u> Day <u>1960</u> Year				
<b>5 SEX</b> <u>F.</u>		<b>6 COLOR OR RACE</b> <u>W.</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8 DATE OF BIRTH</b> <u>JUNE 25, 1894</u>		<b>9. AGE (In years last birthday)</b> <u>66</u> yrs	
<b>10a USUA. OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>H.W.</u>			<b>10b KIND OF BUSINESS OR INDUSTRY</b> <u>O.H.</u>		<b>11 BIRTHPLACE</b> (State or foreign country) <u>MD.</u>			<b>12 CITIZEN OF WHAT COUNTRY?</b> <u>USA.</u>	
<b>13 FATHER'S NAME</b> <u>THOMAS JUSTICE</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>SARAH RICHARD</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) _____ (If yes, give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address _____				
<b>18 CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary congestion</u> <u>151X</u> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinomatosis</u> DUE TO (c) <u>Carcinoma of stomach</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 days.</u> <u>6 mos.</u> <u>1 yr?</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____									
<b>20a ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH [IF EITHER, NOTIFY MEDICAL EXAMINER]			<b>20b DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)						
<b>20c TIME OF INJURY</b> Month _____ Day _____ Year _____ Hour a. m. _____ p. m. _____			<b>20d INJURY OCCURRED</b> While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f (City or town)</b> (County) (State)		
<b>21 I certify that (I) (this hospital) attended the deceased from</b> <u>1950</u> <b>to</b> <u>July 13, 1960</u> <b>that (I) (we) last saw the deceased alive on</b> <u>July 13, 1960</u> <b>and that death occurred at</b> <u>9 P.</u> <b>M, from the causes and on the date stated above.</b>									
<b>22a SIGNATURE</b> <u>GEO. E. WELLS</u>					<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b DATE SIGNED</b>		
<b>22c PHYSICIAN'S NAME (Type)</b> <u>GEO. E. WELLS</u>					<b>22d ADDRESS</b> <u>4100 Edmondson Ave. Balto.</u>				
<b>23a. BURIAL CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>7/16/60</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>LOLTON PARK</u>			<b>23d. LOCATION (City, town, or county)</b> (State) <u>BALTO. MD.</u>		
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <u>WITKE FUN. DIR, 4101 EDMONDSON AVE</u>					<b>25a REC'D BY REGISTRAR</b> <u>JUL 18 60</u>		<b>25b REGISTRAR'S SIGNATURE</b> <u>Walter S. Priddy</u>		



22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)
BURIAL	7-19-66	MCARTHUR MEMORIAL PK	PAIZO Ca	MD
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
C. F. EVANS & SON		8802 Nantuxford RD	JUL 19 '60	Charles E. Krause

VS A15 (4)  
15M 10/57



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7737

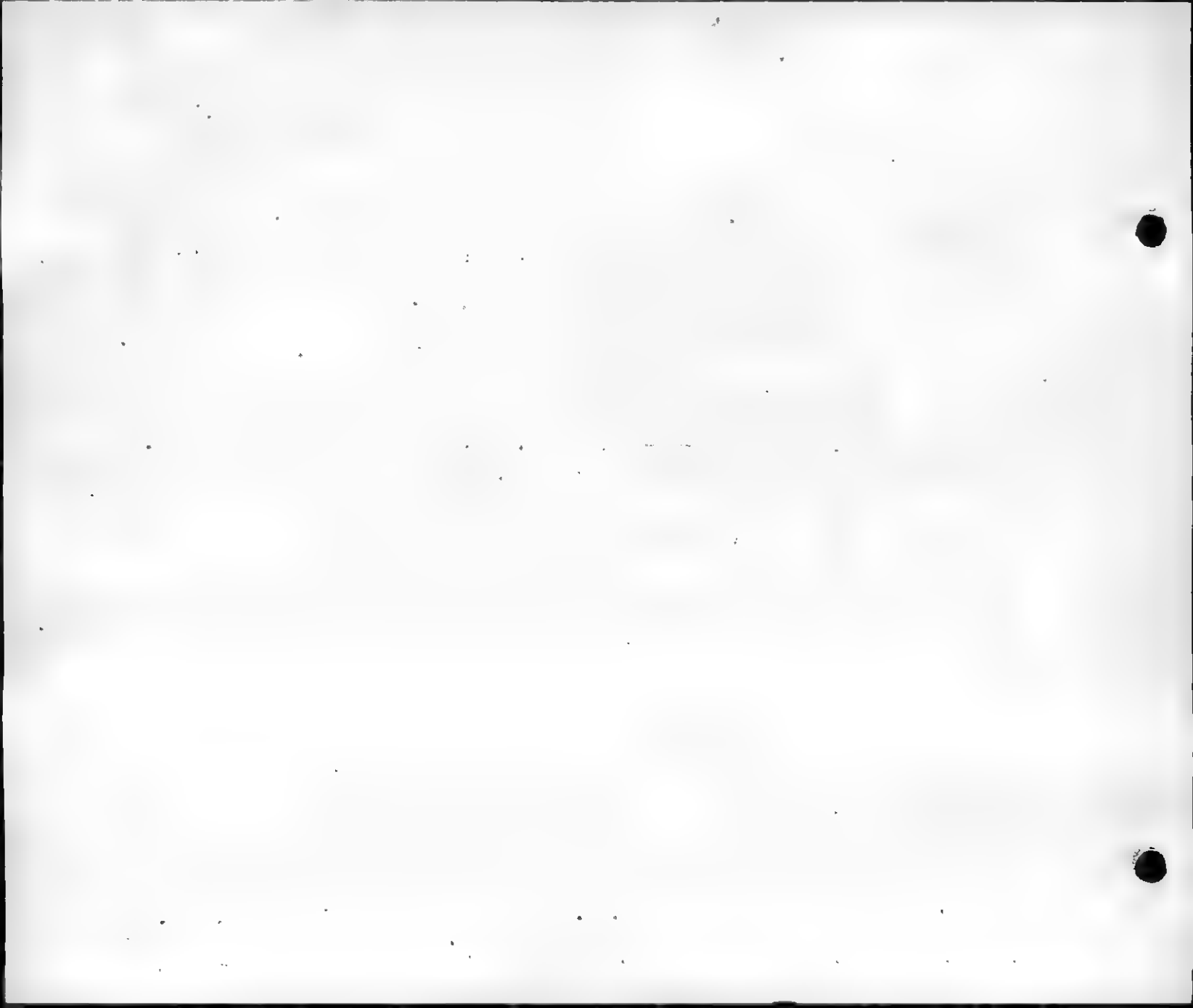
## CERTIFICATE OF DEATH

07710

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>		c. LENGTH OF STAY IN 1b <b>Overlea</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>137 Sipple Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>August</b> Middle <b>Gemeinhardt</b> Last <b>Gemeinhardt</b>		4. DATE OF DEATH Month <b>July</b> Day <b>10</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 3, 1892</b>
9. AGE (In years last birthday) <b>67</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>67</b> Days <b>67</b> Hours <b>67</b> Min <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Checker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transit</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Gemeinhardt</b>		14. MOTHER'S MAIDEN NAME <b>Hanna Stoecker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W. W. # 2 213-10-1004</b>	
17. INFORMANT <b>Mrs. Geraldine Duke</b>		Address <b>137 Sipple Ave. 6</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b> <b>4 1/2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>002X</b> <b>Pulmonary Tuberculosis, heart + lungs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5 Feb</b> , 19 <b>57</b> , to <b>10 July</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>9 July</b> , 19 <b>60</b> , and that death occurred at <b>1011 M</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>8604 Highland Rd Baltimore Md</b> DATE SIGNED <b>Baltimore (4) Md</b>			
ACTUAL SIGNATURE <b>Howard Goodman</b>		PHYSICIAN'S NAME (Type) <b>Howard Goodman</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-14-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Balto. U.S. National</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Losach Funeral Home</b>		ADDRESS <b>7401 Belair Rd</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 15 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Howard</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
7738  
CERTIFICATE OF DEATH

07711

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>1 month</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUMMIT Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>HENRY Frederick GLENSKY</u>		4. DATE OF DEATH <u>July 27 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. AGE (In years lost birthday) <u>78</u> yrs	8. DATE OF BIRTH <u>NOV 18 1881</u>
9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert GLENSKY</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-03-0445</u>	
17. INFORMANT <u>WALTER GLENSKY</u>		Address <u>1102 ELM RD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>			
DUE TO (b) <u>Arteriosclerotic CVD, generalized</u>			
DUE TO (c) _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1959</u> to <u>July 26 1960</u> , that (I) (we) last saw the deceased alive on <u>July 26 1960</u> , and that death occurred <u>over</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Herbert J. Levickas</u> M.D.		22b. DATE SIGNED <u>7/28/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Herbert J. Levickas</u>		22d. ADDRESS <u>5305 East Drive</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-30-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Govanstown Presbyterian</u>		23d. LOCATION (City town or county) <u>Baltimore Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. L. Schomburg</u> ADDRESS <u>11045 Francis St. Baltimore, Md</u>		25a. REC'D BY REGISTRAR <u>AUG 1 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO HO OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or in any event within 72 hours after death.

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15M 11/59

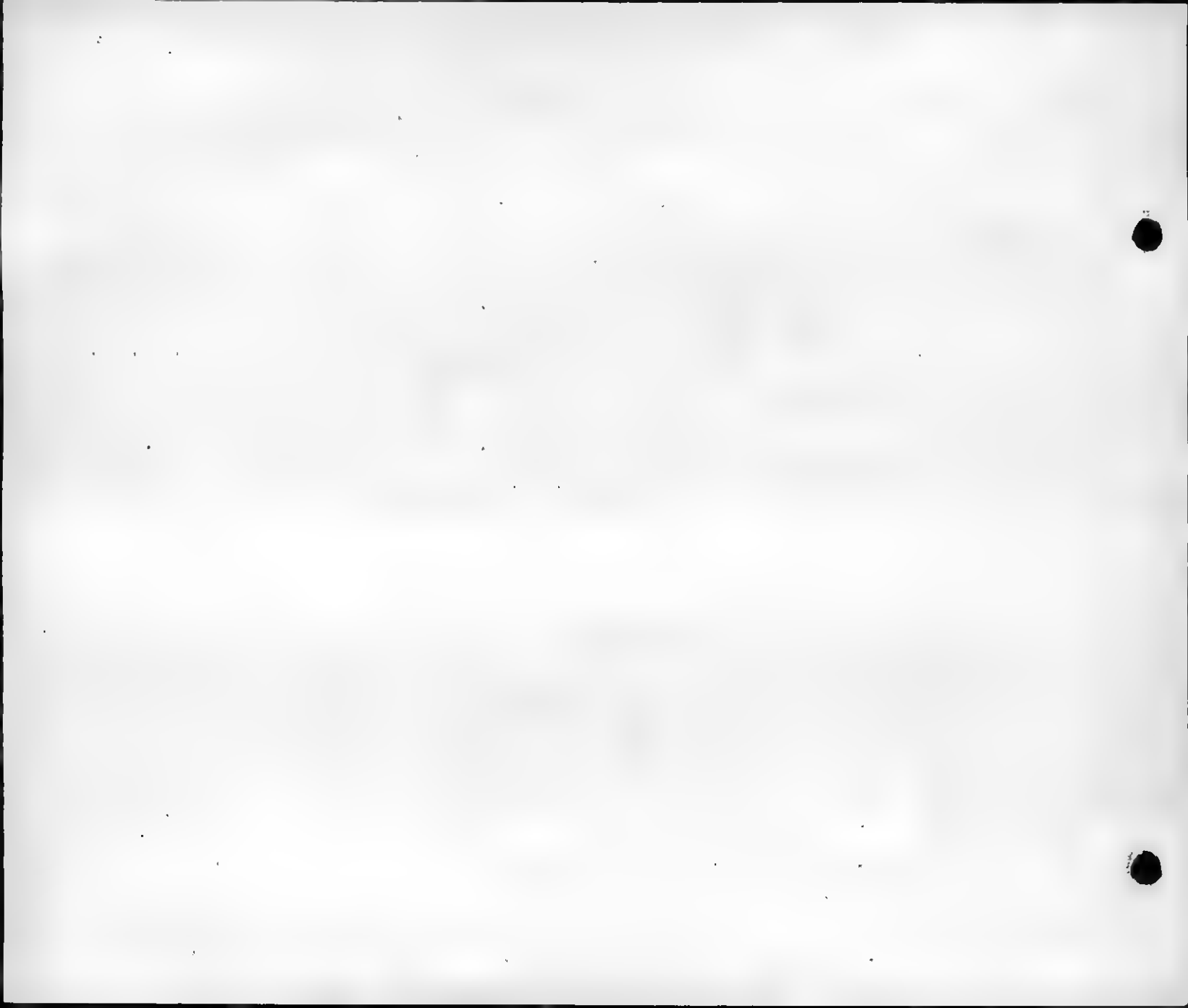
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1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07712

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lansdowne</b>		c. LENGTH OF STAY IN 1b <b>Lansdowne</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2616 Braun Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Katherine T. Goeller</b>		4. DATE OF DEATH Month Day Year <b>July 24, 1960</b>	
5. SEX <b>female</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 28, 1892</b> 9. AGE (In years last birthday) <b>67</b> yrs	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Otten</b>		14. MOTHER'S MAIDEN NAME <b>Julia M. Born</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>John D. Goeller</b>		Address <b>2616 Braun Ave., Lansdowne Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>LYMPHOSARCOMA</b> <b>202.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>15 mos</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 26, 1947</b> to <b>July 24, 1960</b> , that (I) (we) last saw the deceased alive on <b>July 22, 1960</b> , and that death occurred at <b>5 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>C. Arthur Rossberg M.D.</b>		22b. DATE SIGNED <b>7/25/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. Arthur Rossberg</b>		22d. ADDRESS <b>2436 Washington Blvd.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/27/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Elkridge, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		25a. REC'D BY REGISTRAR <b>JUL 27 '60</b>	
ADDRESS <b>4107 Wilkens Ave.</b>		25b. REGISTRAR'S SIGNATURE <b>Carlton S. Kline</b>	



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

7739

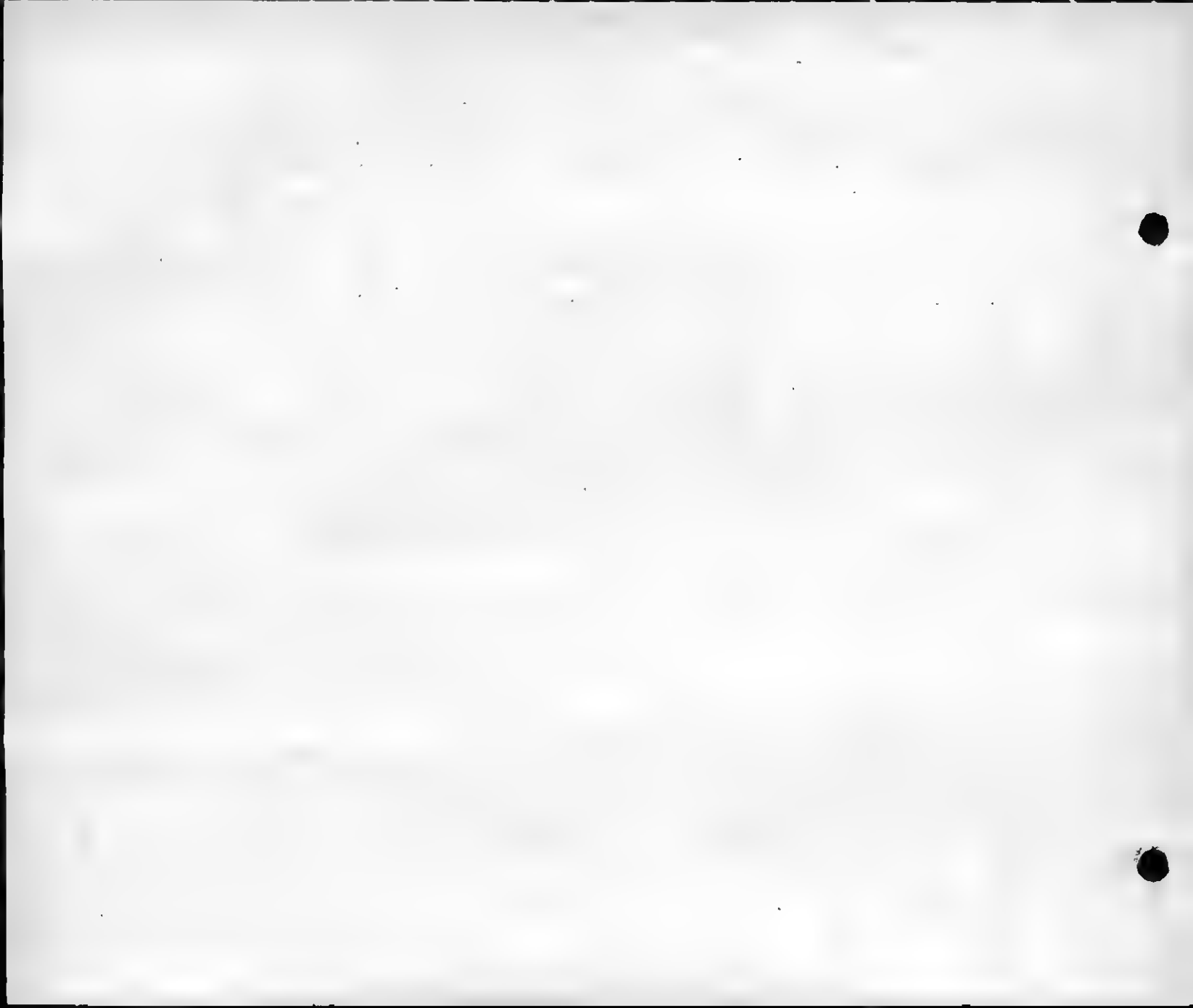
07713

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institut on: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Ches)</u>		c. LENGTH OF STAY IN 1b <u>2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Ches)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Box 466 B. Carroll Island Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF</b> (Type or print) <u>George H. Green</u>				<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>16</u> Year <u>1960</u>			
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Nov. 14 - 1898</u>	
<b>9. AGE</b> (in years lost birthday) <u>61</u> yrs		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>motion picture director</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>md.</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b>		<b>13. FATHER'S NAME</b> <u>George Green</u>					
<b>14. MOTHER'S MAIDEN NAME</b> <u>Cluffy</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)					
<b>16. SOCIAL SECURITY NO.</b> <u>213 58653</u>		<b>17. INFORMANT</b> <u>Gordon V. Green</u> Address <u>(above)</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Coronary arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>one week</u> <u>2 years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Febr. 23 1960</u> <b>to</b> <u>July 15 1960</u> <b>that (I) (we) last saw the deceased alive on</b> <u>July 14 1960</u> <b>and that death occurred at</b> <u>5:00</u> <b>M.</b> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Neopoldo Gross</u>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Neopoldo Gross M.D.</u>				<b>22d. ADDRESS</b> <u>405 Stremmers Run Rd, Balto 21</u>			
<b>23a. BURIAL CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>7-19-60</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>OAK LAWN</u>		<b>23d. LOCATION (City, town, or county) (State)</b> <u>BALTO. CO. MD.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John L. Connelly</u>				<b>ADDRESS</b> <u>918 Eastern Blvd</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>Jul 19 '60</u>	
				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. House</u>			

(M)

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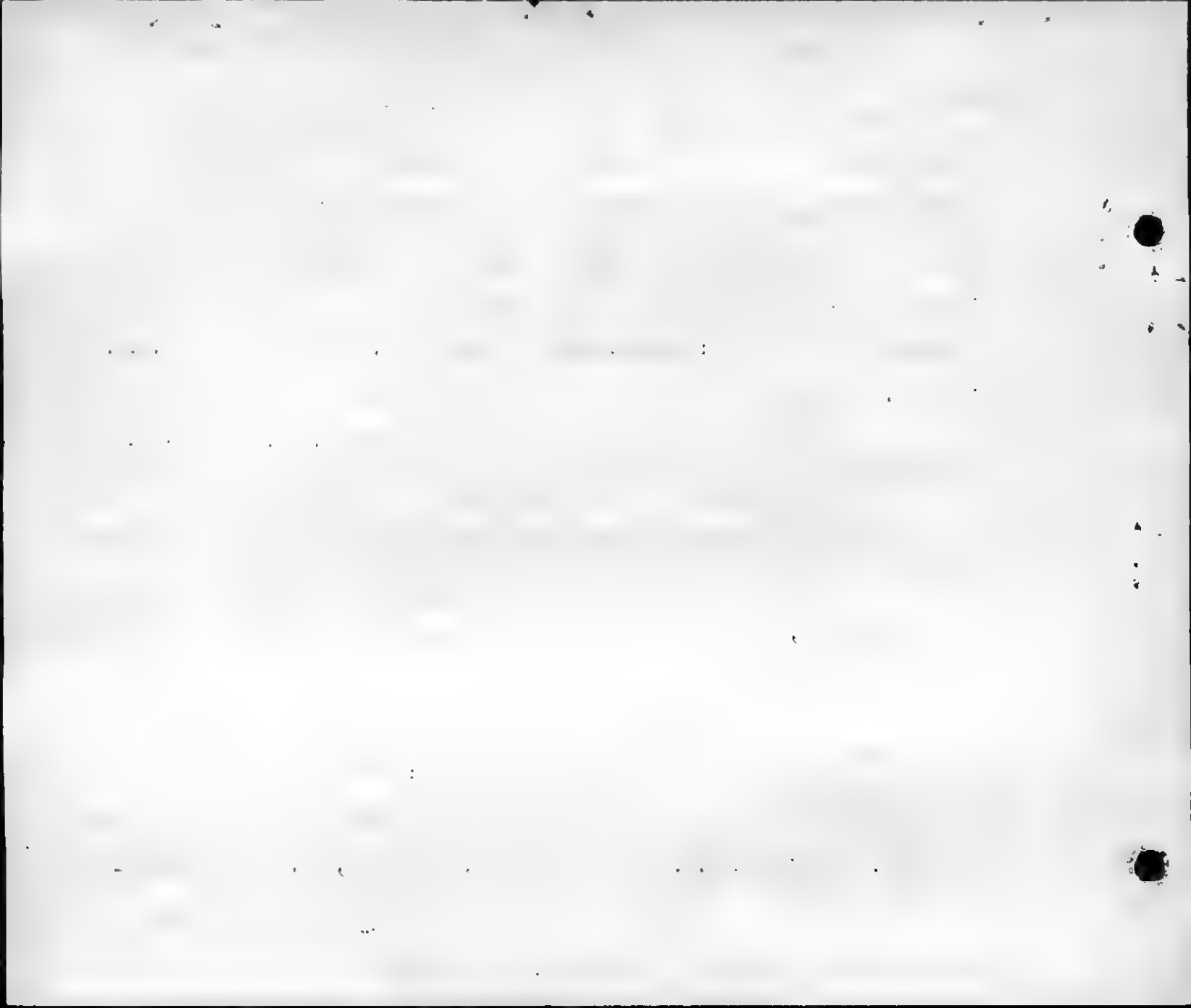
7740

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

07714

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>13 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>320 BIRCHWOOD PLACE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>CONRAD</b> Last <b>GUNZELMAN</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>10</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 2, 1889</b>
9. AGE (In years last birthday) <b>71</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BOOKKEEPER</b>	11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BOOKKEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PACKING HOUSE</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>GEORGE C. GUNZELMAN</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET DIETZ</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>218-12-4534</b>	
17. INFORMANT <b>Clinrec VAH, Balto Md. Ft. Howard Div.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>20.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>EMPHYSEMA, PNEUMONIA</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b>  <b>UNKNOWN</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>June 27, 1960</b> to <b>July 10, 1960</b> , that (we) last saw the deceased alive on <b>July 10, 1960</b> , and that death occurred at <b>11:15 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter J. Pijanowski, M.D.</b>		22b. DATE SIGNED <b>7/11/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER J. PIJANOWSKI, M.D.</b>		22d. ADDRESS <b>VAH, BALTIMORE, MD. - FT. HOWARD DIVISION</b>	
23a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/13/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Tickner Funeral Home, Pa &amp; North Ave. Balto. Md.</b>		25a. REC'D BY REGISTRAR <b>DATE <b>Jul 12 '60</b></b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7741

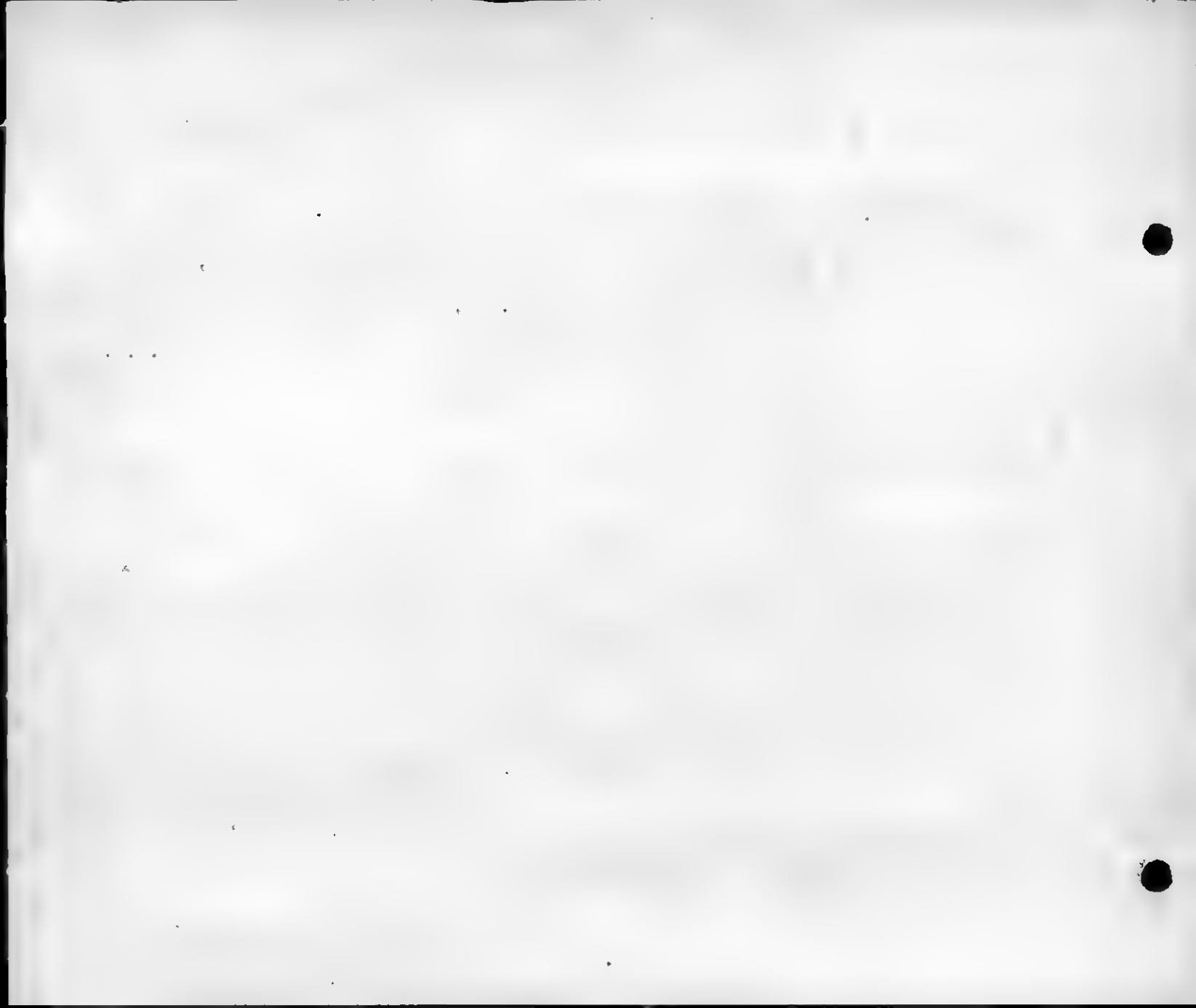
## CERTIFICATE OF DEATH

07715

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex #21</b>				c. LENGTH OF STAY IN 1b <b>Essex #21</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Lasky Ave. Cape May Beach</b>				d. STREET ADDRESS <b>1016 Essex Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>AUGUSTA</b> Last <b>HALL</b>				4. DATE OF DEATH Month <b>July</b> Day <b>26</b> Year <b>19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 13, 1875</b>	9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Godwin</b>				14. MOTHER'S MAIDEN NAME <b>Martha Ross</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Ethel Leary</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory failure</b> DUE TO (b) <b>Intraabdominal abscess</b> DUE TO (c) <b>Cholecystitis (Cholecystectomy)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>19 days</b> <b>23 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive cardiovascular disease, arteriosclerotic</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 15, 1960</b> to <b>July 26, 1960</b> , that I last saw the deceased alive on <b>July 25, 1960</b> , and that death occurred at <b>7:45 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Eugene C. Baumann</b> M.D.				ADDRESS (Street, city or town, state) <b>413 Eastern Ave., Essex 21, Md</b>		DATE SIGNED <b>7-27-60</b>	
PHYSICIAN'S NAME (Type) <b>Eugene C. Baumann</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/30/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sudlersville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Queen Anne County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Bruzdinski</b>				ADDRESS <b>1407 Eastern Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 29 1960</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

MEDICAL CERTIFICATION



OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

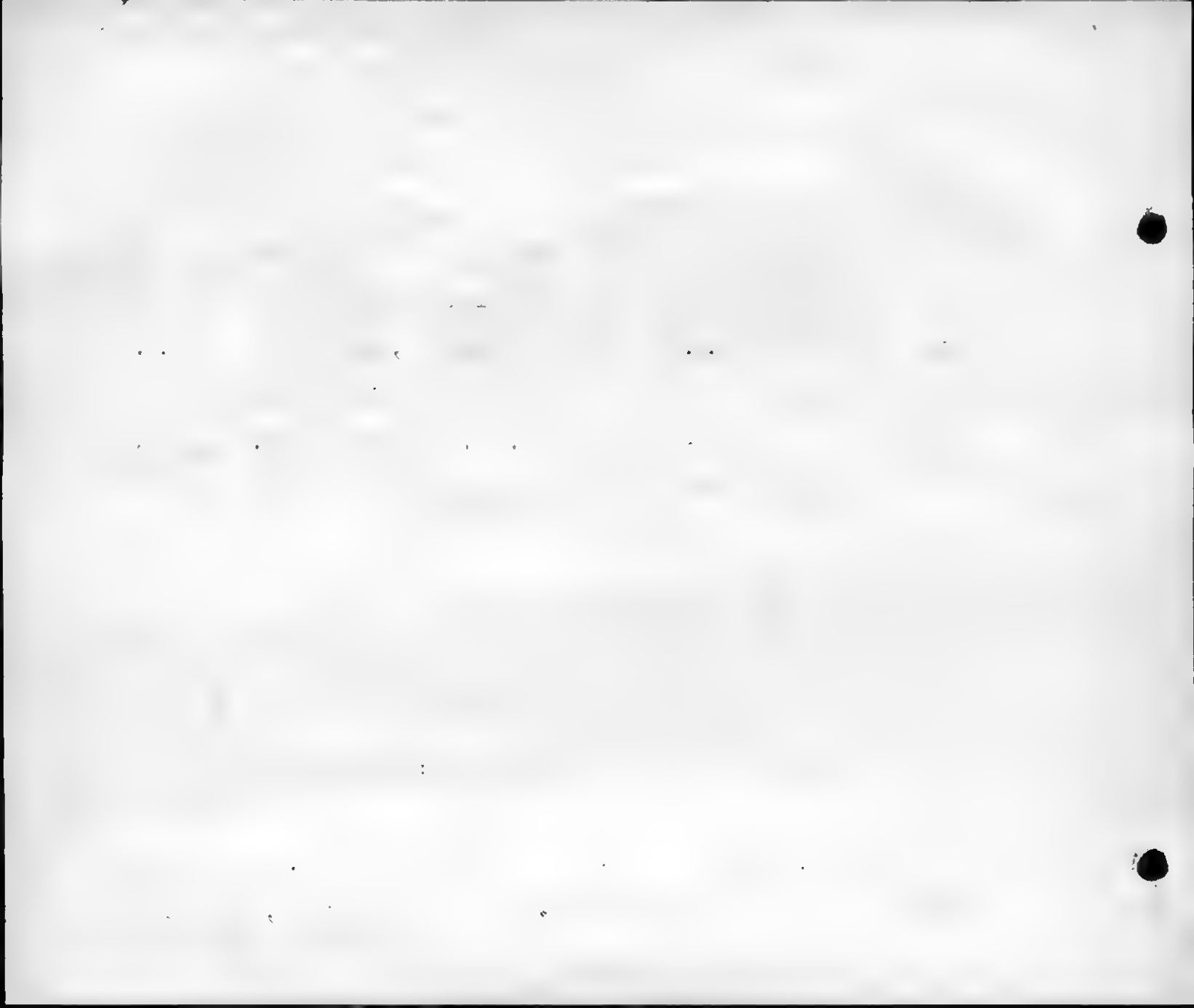
7742

7742

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07716

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> c. LENGTH OF STAY IN 1b <b>38 DAYS</b> d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b> d. STREET ADDRESS <b>3 COLLEGE CREEK TERRACE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NICHOLAS</b> Middle <b>----</b> Last <b>HAMILTON</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>25</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DECEMBER 3, 1893</b>
9. AGE (In years last birthday) <b>66 yrs</b>		10. IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. NAVAL ACADEMY</b>	
11. BIRTHPLACE (State or foreign country) <b>ANNAPOLIS, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM HAMILTON</b>		14. MOTHER'S M.A.DEN NAME <b>HESTER STEWART</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>214-05-2489</b>	
17. INFORMANT <b>CLIN.REC.VAH FT HOWARD DIV. BALTO 18,MD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MARKED HYPERTROPHY &amp; DILATATION OF HEART</b> 34.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ANASARCA</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Edema of the lungs; abscesses of prostate</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>1 month</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 17, 1960</b> to <b>July 25, 1960</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 25, 1960</b> , and that death occurred at <b>9:10AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>WALTER J. PIJANOWSKI, M.D.</b>		22b. DATE SIGNED <b>7/25/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER J. PIJANOWSKI, M.D.</b>		22d. ADDRESS <b>VAH FT HOWARD DIV. BALTO MD</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7-29-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT MORIAH Annap. Natl.</b>	23d. LOCATION (City, town, or county) (State) <b>ANNAPOLIS, MARYLAND</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Reese, Washington St, Annapolis, Md</b>		25a. REC'D BY REGISTRAR <b>JUL 28 '60</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

7743

07717

Item 23b, Film 0267 7/27/60

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		USUAL RESIDENCE (Where deceased lived) (If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Middle River</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>4 Middle River</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rt. 15 Box 183 Balto. 20</i>		e. STREET ADDRESS <i>Rt. 15 Box 183 Balto. 20</i>	
3. NAME OF DECEASED (Type or print) First <i>EVA</i> Middle <i>W</i> Last <i>HAMMOND</i>		4. DATE OF DEATH Month <i>JULY</i> Day <i>19</i> Year <i>1960</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 7, 1886</i>
9. AGE (In years last birthday) <i>74</i> yrs		10. IF UNDER 1 YEAR Months <i>7</i> Days <i>19</i> Hours <i>19</i> Min <i>60</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maine</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>L. L. Skinslow</i>		14. MOTHER'S MAIDEN NAME <i>Estelle Perkins</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Flournoy Senech</i>		Address <i>(Same as above)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Decompensation</i> DUE TO (b) <i>Arterio-sclerotic Heart Disease</i> DUE TO (c) <i>3 1/2 yrs</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>2 hours</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>April 18, 1959</i> to <i>July 19, 1960</i> , that (I) (we) last saw the deceased alive on <i>May 16, 1960</i> , and that death occurred on <i>July 19, 1960</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Joseph Miceli</i> M.D.		22b. DATE SIGNED <i>7/20/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>JOSEPH MICELI M.D.</i>		22d. ADDRESS <i>108 S. TAYLOR AVE BALTO. 21, MD.</i>	
23a. BURIAL, CREMATION, REMOVAL, VA. 30. (If)		23b. DATE THEREOF <i>July 21, 1960</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>RIVERSIDE ANNEX</i>		23d. LOCATION (City, town, or county) (State) <i>SOUTH PARIS MAINE</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Connelly</i>		25a. REC'D BY REGISTRAR <i>418 Eastern Blvd Balto. 21</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>		DATE <i>JUL 21 '60</i>	

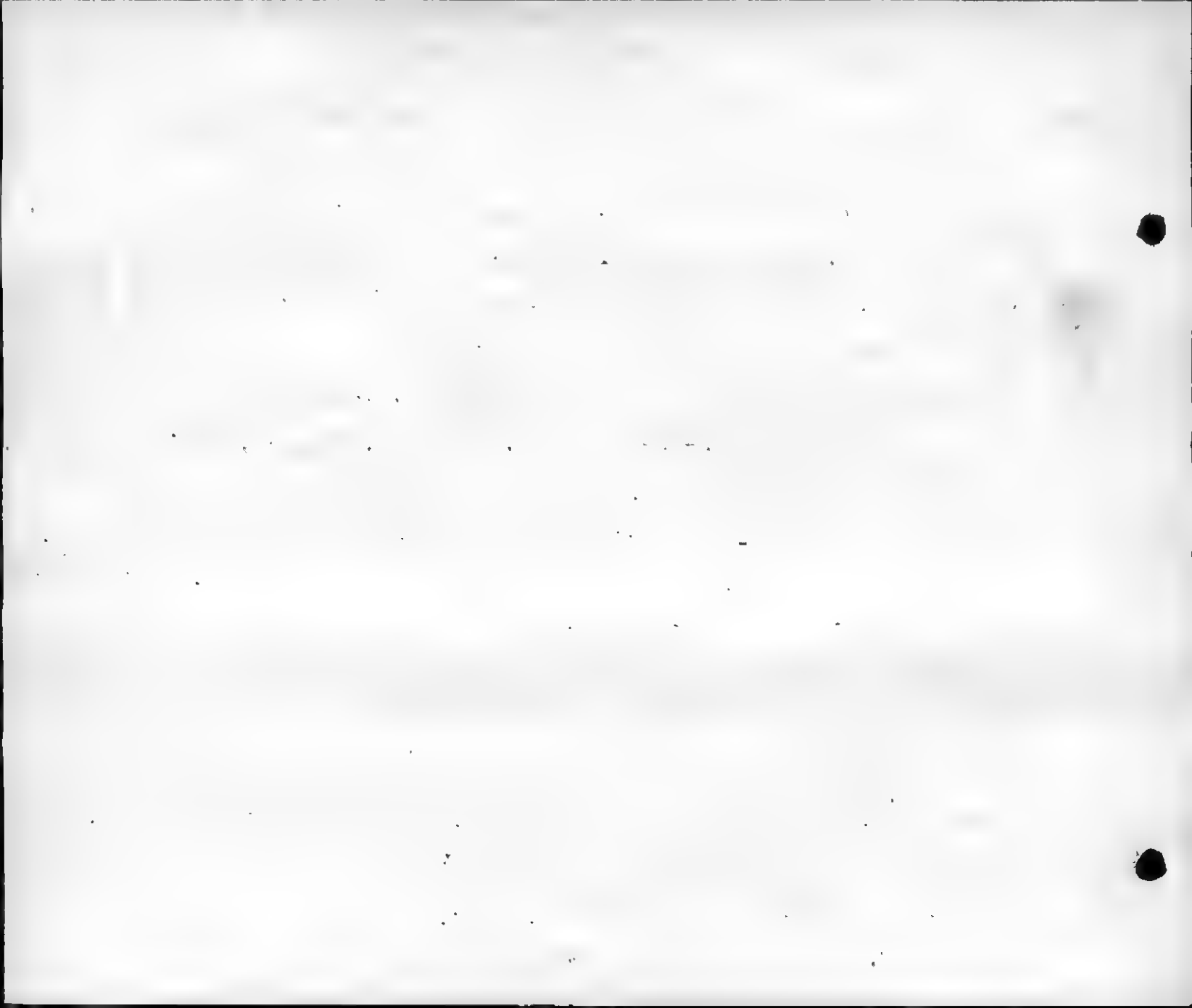


7744  
CERTIFICATE OF DEATH

Reg. Dist. No. 07718

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>812 Regester Avenue</u>		d. STREET ADDRESS <u>16510 Loch Hill Court</u>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Blanche Olivia Hargett</u>		4. DATE OF DEATH <u>July 11th</u> 19 <u>60</u>	
5 SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25, 1882</u>
9. AGE (in years last birthday) <u>77</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alphonso Claggett</u>		14. MOTHER'S MAIDEN NAME <u>Molly V. Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO <u>212-01-9594</u>	
17. INFORMANT <u>Mr. Arthur M. Hargett, 6510 Loch Hill Ct.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 795.5 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Secondary to heart disease</u> (c) <u>Degeneration of the pulmonary artery</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>4 weeks</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March</u> 19 <u>54</u> , to <u>11 July</u> 19 <u>60</u> that I last saw the deceased alive on <u>12 July</u> 19 <u>60</u> , and that death occurred at <u>10:22 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>812 Regester Avenue, Baltimore, Md.</u> DATE SIGNED <u>11 July 1960</u> ACTUAL SIGNATURE <u>Dr. Edgar Lockard</u> PHYSICIAN'S NAME (Type) <u>Baltimore - 1. 9th</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/14/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>JUL 14 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSTS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove 72 hours after the death. The registror prior to burial, cremation, or removal, and in any event within 72 hours after the death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7745

07719

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto. Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines - Fusting Ave.</b>				d. STREET ADDRESS <b>The Marylander Apts.</b>			
3. NAME OF DECEASED (Type or print) First <b>BLANCHE</b> W. Middle <b>HARRIS</b> Last				4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>1960</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 26, 1885</b>	
9. AGE (In years lost birthday) <b>74</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>Virginia</b>			
13. FATHER'S NAME <b>Albert F. Shackelford</b>				14. MOTHER'S MAIDEN NAME <b>Mary Catherine Wallace</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Maude S. Powell - 307 Southway - Balto. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia - Chr nephritis</b> DUE TO (b) <b>arterio sclerosis</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 19 1960</b> to <b>July 5 1960</b> , that (I) (we) last saw the deceased alive on <b>July 4 1960</b> , and that death occurred at <b>8 A</b> M, from the causes and on the date stated above							
22a. SIGNATURE <b>D. BERNARD J COHEN</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>D. BERNARD J COHEN</b>				22d. ADDRESS <b>The Marylander Apts.</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/8/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tinkler &amp; Sons - Balto 17</b>				25a. REC'D BY REGISTRAR <b>DATE 6 '60</b>		25b. REGISTRAR'S SIGNATURE <b>J. J. S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



7746

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07720

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN lb <b>31 DAYS</b> d. NAME OF HOSPITAL (if not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>833 N COLLINGTON AVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EARL</b> Middle <b>--</b> Last <b>HARVEY</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>7</b> Year <b>1960</b>	
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>AUGUST 28 1888</b>
9 AGE (in years last birthday) <b>71 yrs</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b> Hours <b>1</b> Min <b>0</b>	IF UNDER 24 HRS Hours <b>1</b> Min <b>0</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GOVERNMENT</b>	11 BIRTHPLACE (State or foreign country) <b>LYNCHBURG, VA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>JESSE HARVEY</b>	
14. MOTHER'S MAIDEN NAME <b>FANNIE STINNETT</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW I</b>	
16. SOCIAL SECURITY NO. <b>215-10-3933</b>		17 INFORMANT <b>CLIN REC VAH BALTO MD FT HOWARD DIV</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE WITH CARDIAC INSUFFICIENCY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>UNKNOWN</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. Adenocarcinoma of rectum. 2. Emphysema of lung due to unknown cause</b>			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JUNE 6 1960</b> to <b>JULY 7 1960</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>JULY 7 1960</b> , and that death occurred at <b>10:25 A</b> M, from the causes and on the date stated above			
22a. SIGNATURE <b>Thomas R. Hood</b>		22b. DATE <b>7/7/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>THOMAS R HOOD</b>		22d ADDRESS <b>VAH BALTO 18 MD FT HOWARD DIVISION</b>	
23a BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>July 11, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	23d. LOCATION (City, town, or county) (State) <b>Balto. Md</b>
24 FUNERAL DIRECTOR'S SIGNATURE <b>Philip E. Crach</b>		25a REC'D BY REGISTRAR <b>JUL 12 '60</b>	
25b REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>			



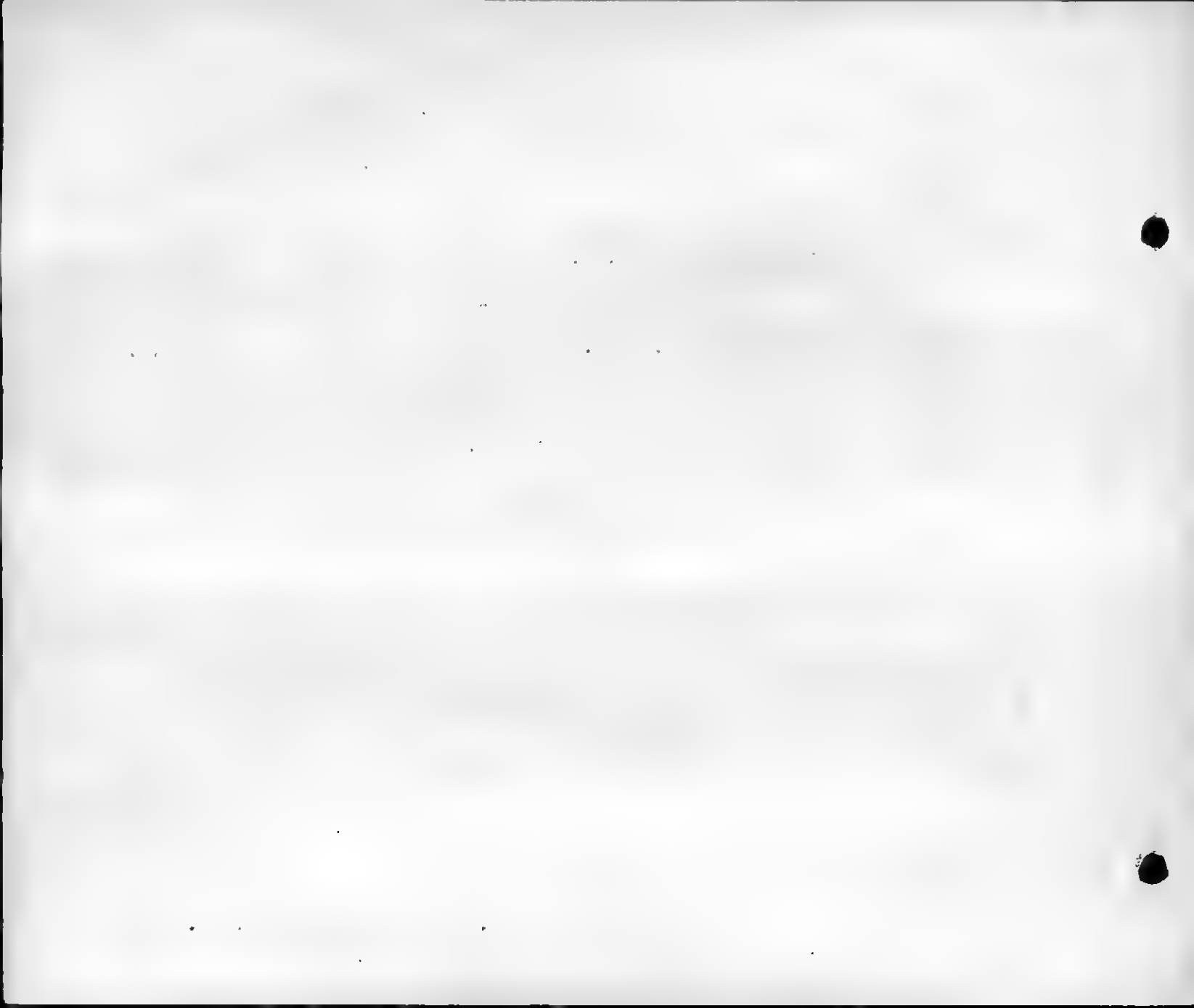
# 1 7747 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 3-3-67 7-17-60 et CERTIFICATE OF DEATH 07721

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN IB <b>8Y 1M 19D</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Gustav</b> Middle <b>C. C.</b> Last <b>Hauser</b>		4. DATE OF DEATH Month <b>July</b> Day <b>4</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-22-1882</b>
9. AGE (In years last birthday) <b>77</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cartographic Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>John Hauser</b>		14 MOTHER'S MAIDEN NAME <b>Amelia Rommel</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17 INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCOPNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>HYPERTENSIVE CARDIAC DISEASE</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JULY 15, 1959</b> to <b>JULY 4, 1960</b> , that I last saw the deceased alive on <b>JULY 4, 1960</b> , and that death occurred at <b>9:45 A.M.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>P. K. Yip</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>Spring Grove State Hospital 7/4/60</b>	
PHYSICIAN'S NAME (Type) <b>P. K. YIP, M.D.</b>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/7/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner &amp; Sons - Balto</b>		24a. REC'D BY REGISTRAR <b>JUL 5 1960</b>	
ADDRESS <b>Balto</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. J. Lickner</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7748

CERTIFICATE OF DEATH

07722

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>16 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>1803 DUKELAND ST</b>			
3 NAME OF DECEASED (Type or print) First <b>MAURICE</b> Middle <b>---</b> Last <b>HENDERSON</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>19</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>JULY 4, 1890</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TRANSPORTATION</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>HENRY HENDERSON</b>				14. MOTHER'S MAIDEN NAME <b>ELIZA JONES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17 INFORMANT <b>Clin Rec VAH Balto 18, Md Ft Howard Division</b>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, RIGHT LOWER LOBE</b> <b>446X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>NEPHROSCLEROSIS, ADVANCED</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>UNKNOWN</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that <del>he</del> (this hospital) attended the deceased from <b>July 3, 1960</b> to <b>July 19, 1960</b> , that <del>he</del> (we) last saw the deceased alive on <b>July 19, 1960</b> , and that death occurred at <b>2:10 P</b> M, from the causes and on the date stated above.							
22a SIGNATURE <i>Walter J. Pijanowski</i>				22b DATE SIGNED			
22c PHYSICIAN'S NAME (Type) <b>WALTER J. PIJANOWSKI, M.D.</b>				22d ADDRESS <b>VAH FT HOWARD DIV. BALTO 18, Md</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/22/60</b>		23c NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S Phillips</b>				25a REC'D BY REGISTRAR DATE <b>JUL 26 '60</b>		25b REGISTRAR'S SIGNATURE <i>Arthur S. Phillips</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7749  
CERTIFICATE OF DEATH

Reg. Dist. No.

07723

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2mth12dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore County Zone 28</b>	
f. STREET ADDRESS <b>1136 Daniels Avenue</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Virginia</b> Middle <b>Drury</b> Last <b>Henneman</b>		4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 3, 1915</b>
9. AGE (In years last birthday) <b>44 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>nurse</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>William H. Wolfe</b>		14. MOTHER'S MAIDEN NAME <b>Sylvia Garner</b>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>215 18 9078</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 22, 1960</b> , to <b>July 5, 1960</b> , that I last saw the deceased alive on <b>July 5, 1960</b> , and that death occurred at <b>5:50p</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>ARISTIDES M. SIMPOULOS</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 7-5-60</b>	
PHYSICIAN'S NAME (Type) <b>ARISTIDES M. SIMPOULOS Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/7/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke</b>		ADDRESS <b>410 E. ...</b>	
24a. REC'D BY REGISTRAR <b>JUL 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7750

## CERTIFICATE OF DEATH

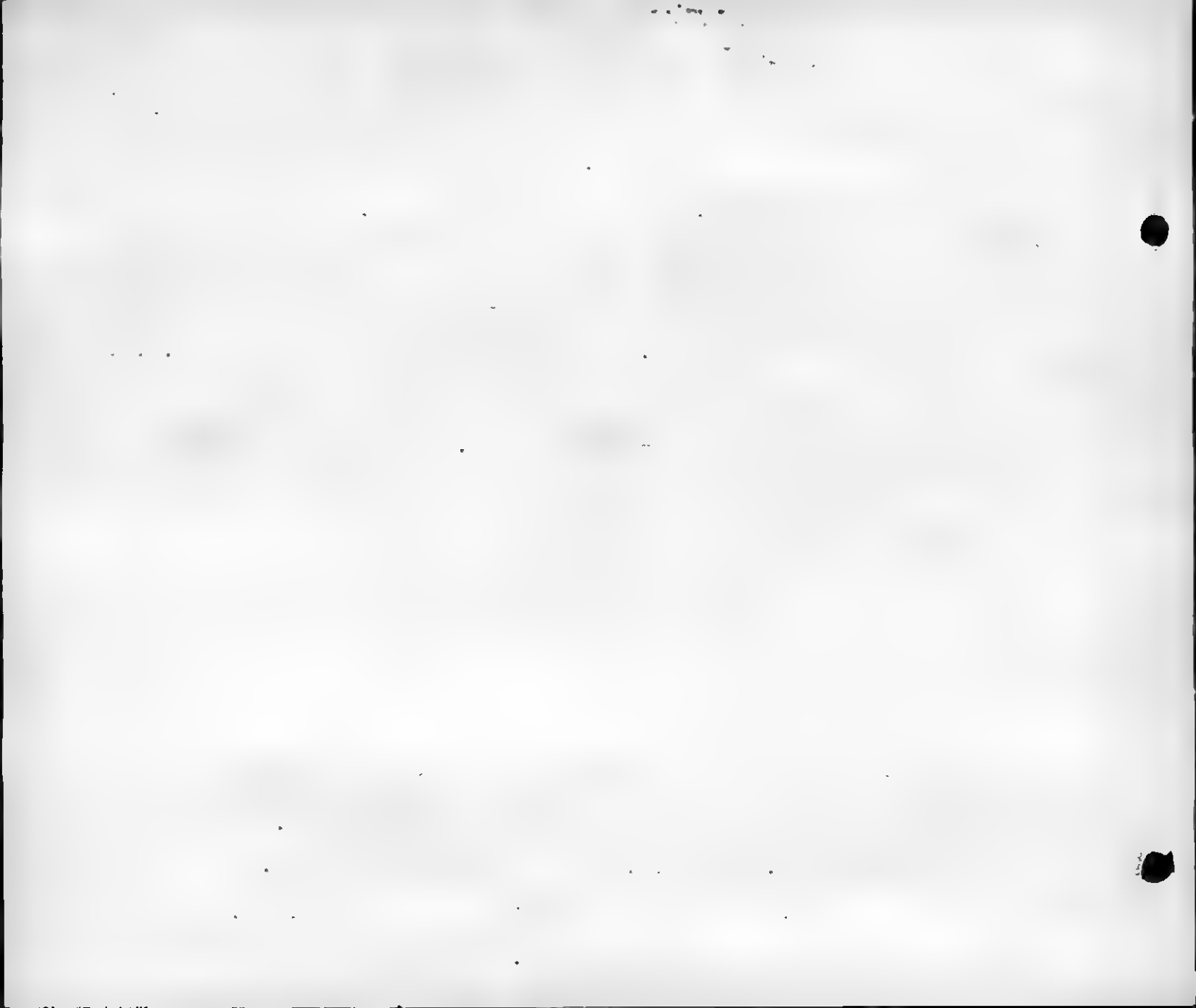
07724

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparks</b>				c. LENGTH OF STAY IN 1b <b>30 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glencoe Rd.</b>				e. STREET ADDRESS <b>Glencoe Rd.</b>			
3. NAME OF DECEASED (Type or print) <b>Robert Edwin Hidey</b>				4. DATE OF DEATH Month <b>7</b> Day <b>11</b> Year <b>1960</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-2-1902</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours M-n.		11. IF UNDER 24 HRS: Months Days Hours M-n.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>shipping clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>dept. store</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>William Hidey</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>X Yes WW I</b>				16. SOCIAL SECURITY NO. <b>215-18-7243</b>		17. INFORMANT <b>Alice C. Hidey</b> Address <b>above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>A. S. C. V. D.</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>5 hours</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>7-11-60</b> to <b>April 19 1960</b> , that I last saw the deceased alive on <b>7-11-60</b> , and that death occurred at <b>3:15 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walter T. Kees</b>				ADDRESS (Street, city or town, state) <b>Cockeysville, Md.</b>			
DATE SIGNED <b>7-14-60</b>							
PHYSICIAN'S NAME (Type) <b>Walter T. Kees M.D.</b>				Cockeysville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-14-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Jessop Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Sparks, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson4, Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>7-14-60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

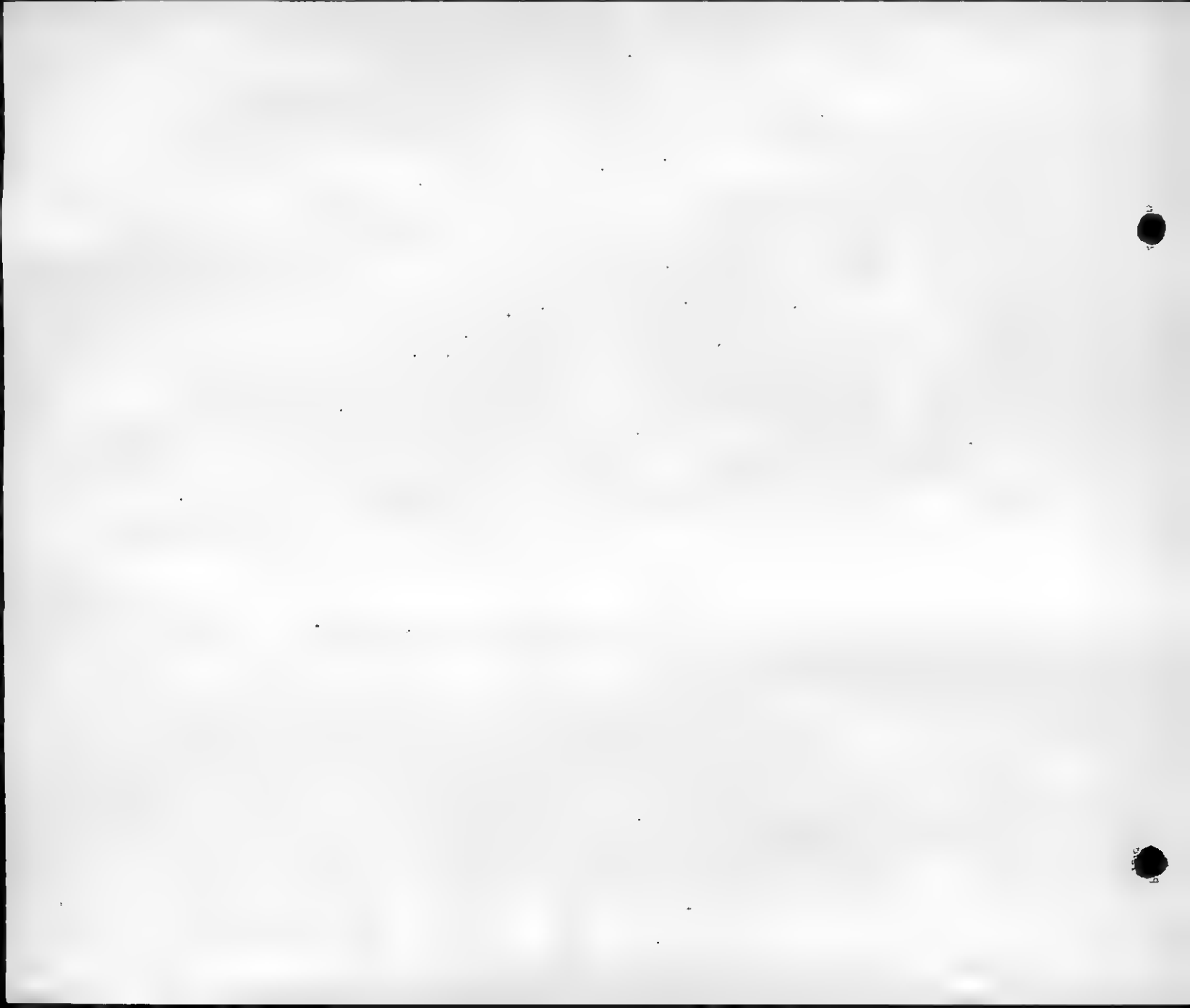
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15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

7682

07725

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1739 Elm Ave.</u>				e. STREET ADDRESS <u>1739 Elm Ave.</u>					
3. NAME OF DECEASED (Type or print) <u>Ada F. Hunter</u>				4. DATE OF DEATH <u>July 7 1960</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 13, 1885</u>	9. AGE (In years lost birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>John R. Hatfield</u>				14. MOTHER'S MAIDEN NAME <u>Fannie E. Hatfield</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Cloyton Hunter</u> Address <u>1739 Elm Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Angina Pectoris. Old Myocardial Infarction</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>7/1, 1959</u> to <u>7/7, 1960</u> that (I) (we) last saw the deceased alive on <u>7/7, 1960</u> , and that death occurred at <u>10:10</u> M. from the causes and on the date stated above									
22a. SIGNATURE <u>Dr. Frederick m</u>				22b. DATE SIGNED <u>7/7/60</u>					
22c. PHYSICIAN'S NAME (Type) <u>Dr. Frederick m</u>				22d. ADDRESS <u>1305 Francis Ave. Balto 27 MD</u>					
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/9/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Poplar Springs Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Mt. Airy, Howard, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrose, Inc. 1328 Sulfur Springs Rd</u>				25a. REC'D BY REGISTRAR <u>Jul 12 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7751  
CERTIFICATE OF DEATH

Reg. Dist. No.

07726

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>11d.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHATONSVILLE</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOUSE IN TIMES.</u>		d. STREET ADDRESS <u>3100 3rd St.</u>	
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>1. LOUIS W. IRWIN</u>		4. DATE OF DEATH Month <u>7</u> Day <u>9</u> Year <u>60</u>	
5. SEX <u>111</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-10-77</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSE</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas J.</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Martin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Family - Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma, Metastatic generalized</u> 1777X DUE TO (b) <u>Carcinoma, Prostate</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>4 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, Arteriosclerotic Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/7</u> , 19 <u>50</u> to <u>7/9</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7-9</u> , 19 <u>60</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Benjamin Bertram</u> M.D.		ADDRESS (Street, city or town, state) <u>5010 H. H. H. Hwy</u> DATE SIGNED <u>7/12/60</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>111</u>		22b. DATE THEREOF <u>7-13-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>111</u>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>JUL 15 '60</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7752

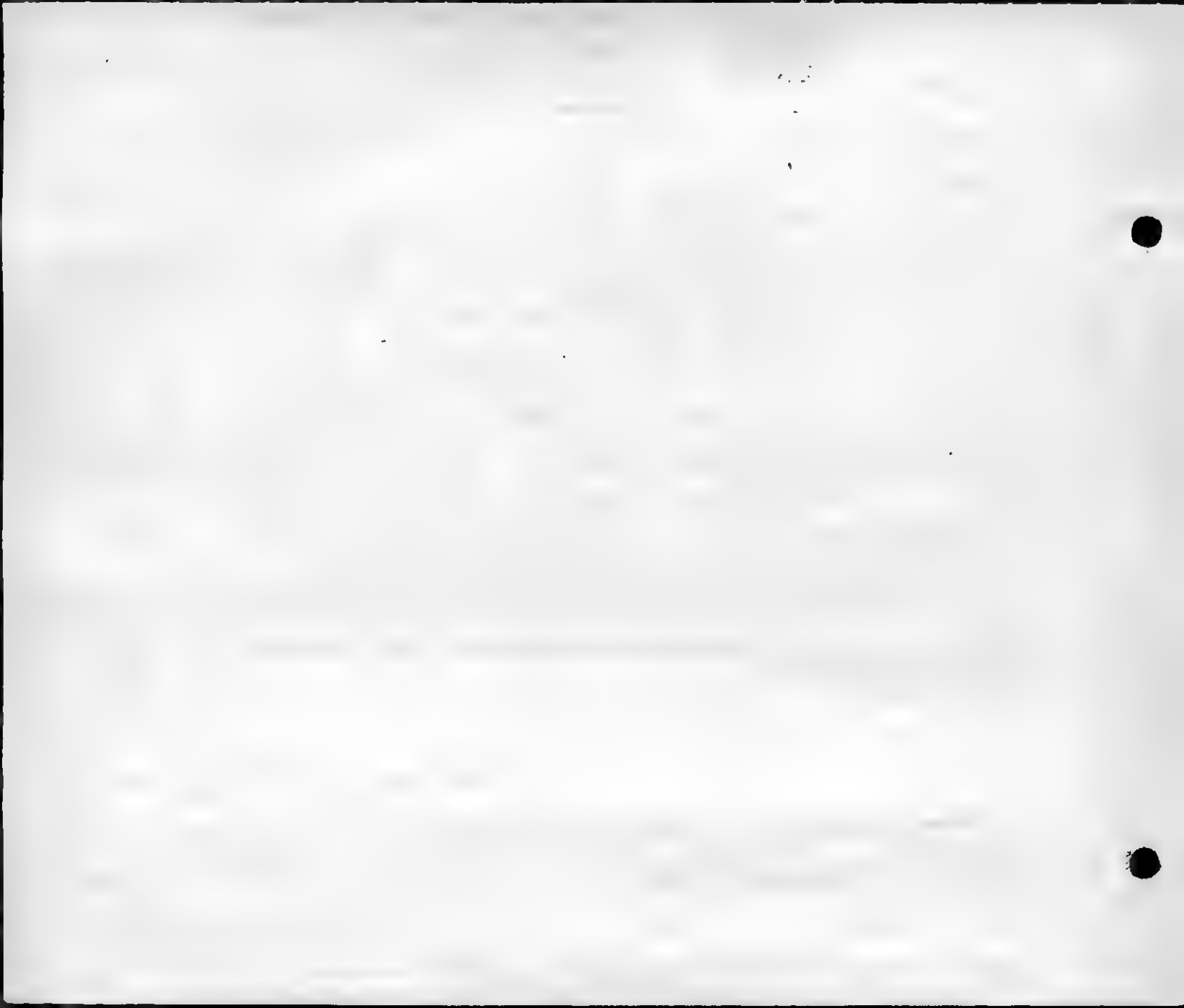
## CERTIFICATE OF DEATH

Reg. Dist. 47727

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TIMONIUM</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TIMONIUM</b>			
c. LENGTH OF STAY IN b. <b>15 YEARS</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>56 H Courtney Jenifer. JENIFER ROAD.</b>				d. STREET ADDRESS <b>JENIFER ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>DOROTHY DELIMA JACKSON</b>				4. DATE OF DEATH Month Day Year <b>JULY 11 1960</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 11, 1911</b>	
9. AGE (In years last birthday) <b>48</b> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>JOHN B. THOMAS</b>				14. MOTHER'S MAIDEN NAME <b>EVA PEARL CHENOWETH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Min Carroll Jackson JENIFER ROAD TIMONIUM</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE + CHRONIC UREMIA</b> DUE TO (b) <b>" + " Congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>BRIGHT'S DISEASE (acute + chronic glomerulonephritis)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>32 YEARS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>DECEMBER</b> , 19 <b>59</b> , to <b>JULY 11</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>JULY 8</b> , 19 <b>60</b> , and that death occurred at <b>4:40 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>PHOENIX, MARYLAND</b> DATE SIGNED <b>7/11/60</b>							
ACTUAL SIGNATURE <b>Henry L. McCorkle M.D.</b>				JARRETTSVILLE PIKE			
PHYSICIAN'S NAME (Type) <b>Henry L. McCorkle MD</b>				<b>Phoenix, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-14-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MAYS CHAPEL CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>TIMONIUM MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns Leno</b>				ADDRESS <b>Jawson, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 14 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
7753

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

67728

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1yr3mth26dys		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL						d. STREET ADDRESS 1701 Eutaw Place			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Louis		First Louis		Middle L		Last Jacobs		4. DATE OF DEATH Month July		Day 14	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 20, 1892		9. AGE (in years lost birthday) 67 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) physician				10b. KIND OF BUSINESS OR INDUSTRY internal medicine				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benson Jacobs						14. MOTHER'S MAIDEN NAME Sarah Crockin					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 1918 & 1946 216-34-1394		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 18, 1959, to July 14, 1960, that (I) (we) last saw the deceased alive on July 14, 1960, and that death occurred at 3:00 P.M. from the causes and on the date stated above											
22a. SIGNATURE Stella Wachsler, M. D.						22b. DATE SIGNED 7-14-60					
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.						22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial - 18-60				23b. DATE THEREOF 18-60		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION (City, town or county) Baltimore			
24. FUNERAL DIRECTOR'S SIGNATURE JACK LEWIS JR						25a. REC'D BY REGISTRAR DATE JUL 18 1960		25b. REGISTRAR'S SIGNATURE Arthur S. Kline			



CERTIFICATE OF DEATH

Reg. Dist. No.

7754

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) b. STATE <u>Baltimore</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1906 Brechtwerk Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Parish Nursing Home</u>		d. STREET ADDRESS <u>2V 01-9</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Minnie E. James</u>		4. DATE OF DEATH Month Day Year <u>7 18 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-18-1881</u>
9. AGE (In years last birthday) <u>79 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Becker</u>		14. MOTHER'S MAIDEN NAME <u>Elyzabeth McVoy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>215-24-8637</u>	
17. INFORMANT <u>Donathy Hardesty</u>		Address <u>1906 Brechtwerk Ave Baltimore</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, general</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>50.0</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec. 28, 1946</u> to <u>July 18, 1960</u> , that I last saw the deceased alive on <u>July 18, 1960</u> , and that death occurred at <u>8:40 AM</u> , from the causes and on the date stated above			
ACTUAL <u>L. Arthur Rossberg</u> M.D.		ADDRESS (Street, city or town, state) <u>2436 Washington Blvd Baltimore 30, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>C. Arthur Rossberg, M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-20-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Bur</u>	22d. LOCATION (City, town, or county) (State) <u>Fredrick Rd Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Foulson</u>		24b. REGISTRAR'S SIGNATURE <u>John S. Foulson</u>	
ADDRESS <u>2354 Wash Blvd Baltimore</u>		24a. REC'D BY REGISTRAR <u>JUL 21 '60</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7755

## CERTIFICATE OF DEATH

07730

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>7 0 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stella Maris Hospice</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Virginia Lee Jefferies</b>		4. DATE OF DEATH Month Day Year <b>July 10th 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/28/1867</b>
9. AGE (In years last birthday) yrs <b>92</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>10 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Singer Sewing Machine Co</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Isaac Potee</b>		14. MOTHER'S MAIDEN NAME <b>Anna Wolf</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Mrs. Margaret E. Grace, 2523 Windsor Road</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>Generalized Arteriosclerotic Cardio</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Renal Vascular Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>10 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 6, 1956</b> to <b>July 10, 1960</b> that I last saw the deceased alive on <b>July 9, 1960</b> , and that death occurred at <b>11:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>7501 York Rd 7/10/60</b>	
PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell - M.D.</b>		<b>Towson Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-13-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		ADDRESS <b>1217 St. Paul Street</b>	
24a. REC'D BY REGISTRAR <b>JUL 12 '60</b>		24b. REGISTRAR'S SIGNATURE <b>William E. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be joined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7756

07731

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Res dence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>654 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>733 GREENMOUNT AVENUE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>E</b> Last <b>JONES</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>19</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 23 1891</b>
9. AGE (In years last birthday) <b>69 yrs</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>JANITOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOTEL</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Tillie Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. INFORMANT <b>Clin Rec Vet Adm Hosp Baltol8 Md Ft Howard Div.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>491-X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral infarct, old; Marked Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 4 1958</b> to <b>July 19 1960</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 19 1960</b> , and that death occurred at <b>11:45AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Walter J. Pijanowski</i>		22b. DATE <b>7/20/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER J. PIJANOWSKI, M.D.</b>		22d. ADDRESS <b>VAH BALTO 18, MD FT HOWARD DIVISION</b>	
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-22-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy O Wilson</b>		25a. REC'D BY REGISTRAR <b>JUN 26 1960</b>	
25b. REGISTRAR'S SIGNATURE <i>Clifford E. Howard</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

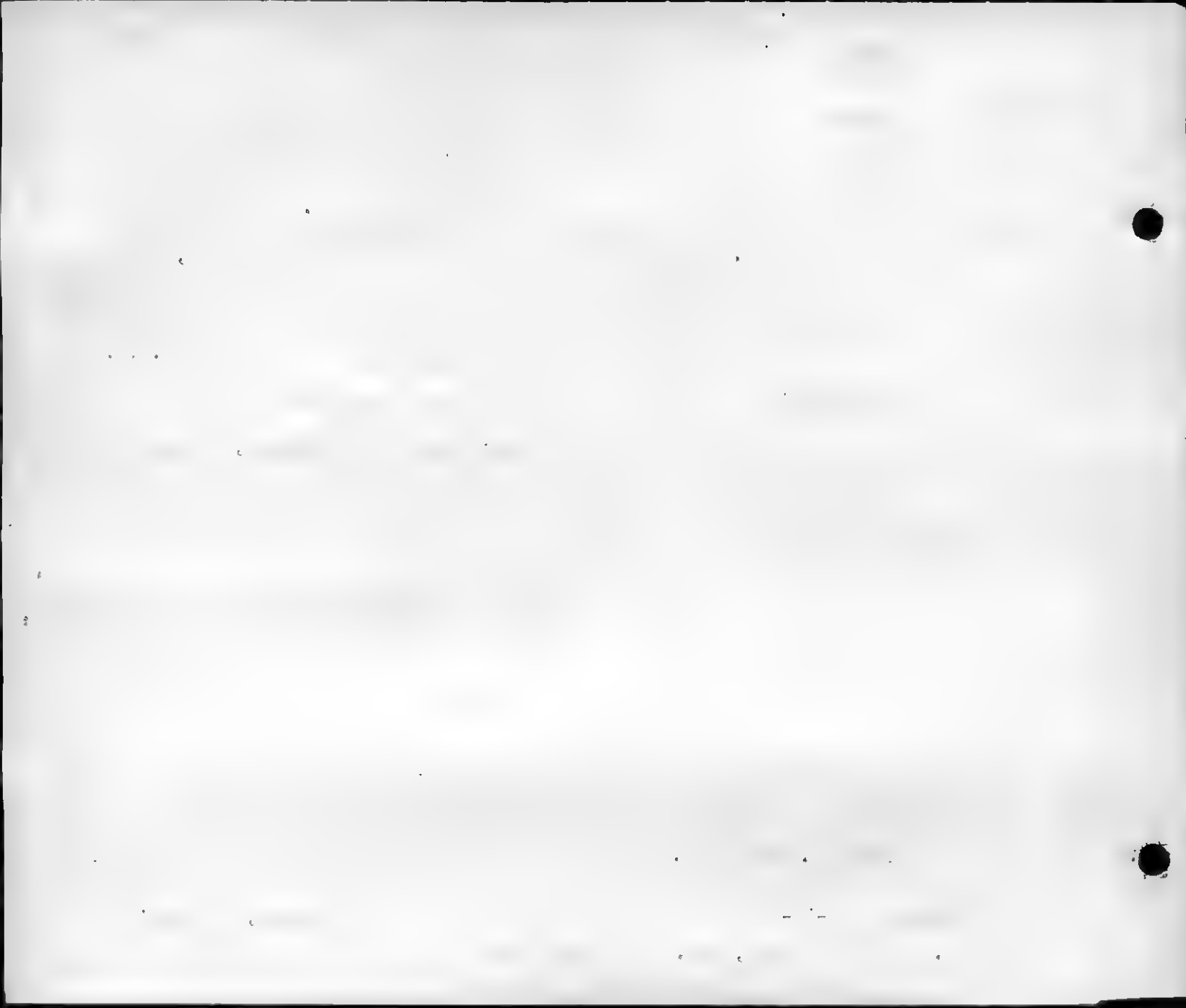
CERTIFICATE OF DEATH

07732

7757

Item 8 filed 11-14-60 et

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Presbyterian Home</b>		d. STREET ADDRESS <b>5006 Denmore Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Anna H. Kemp</b> Middle Last		4. DATE OF DEATH Month <b>July 8,</b> Day Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1873</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Herman Waydelin</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Glek</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Presbyterian Home Towson, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>GENERALIZED HYPERTENSION</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 weeks</b> <b>4 years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m. p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-3-60</b> 19 <b>60</b> to <b>11-8-60</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>11-4-60</b> 19 <b>60</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Sidney J. Venable, Jr.</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Sidney J. Venable, Jr.</b>		22d. ADDRESS <b>725 York Ave. Baltimore, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-11-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Louden Park</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons, Inc. 1900 Eutaw Place</b>		25a. REC'D BY REGISTRAR <b>Jul 12 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

07733

7758

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenarm Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sister Mary Clarita</b> Middle <b>Kern</b> Last		4. DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 8, 1892</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles Kern</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Wunerstabb</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) If yes, give war or dates of service	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Sister M. Peter Fourier</b> Address <b>Notch Cliff, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion sudden</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <b>Coronary insufficiency</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March</b> , 19 <b>56</b> , to <b>July</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>June 14</b> , 19 <b>60</b> , and that death occurred at <b>7:00 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7501 York Road- Towson 4, Md.</b> DATE SIGNED <b>7/3/60</b>			
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>		PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/5/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Villa Maria Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Notch Cliff near Towson Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles S. Zeller</i>		24a. REC'D BY REGISTRAR <b>6224 Eastern Ave. Balt 24 Md</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7759

## CERTIFICATE OF DEATH

07734

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>618 Register Avenue</u>				d. STREET ADDRESS <u>618 Register Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Theodore</u> Middle <u>Edward</u> Last <u>Kesting</u>				4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 6, 1898</u>	
9. AGE (In years last birthday) yrs <u>61</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u>60</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Beavin Const. Engineers</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Martin Kesting</u>				14. MOTHER'S MAIDEN NAME <u>Margaret (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-38-7669</u>		17. INFORMANT Address <u>Mrs. Helen M. Kesting, 618 Register Avenue</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Compensation of Paraneoplasia</u> DUE TO (c) <u>lying cause lost.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>8</u> P. M. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 6, 1960</u> to <u>July 7, 1960</u> , that I last saw the deceased alive on <u>July 6, 1960</u> , and that death occurred at <u>8:25 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2926 E. Calhoun Springs</u> DATE SIGNED <u>Baltimore</u>							
ACTUAL SIGNATURE <u>J. Henry Haase</u>				M.D. <u>Baltimore</u>			
PHYSICIAN'S NAME (Type) <u>J. Henry Haase M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-9-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR <u>JUL 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Haase</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7760

## CERTIFICATE OF DEATH

Reg. Dist. No. 027735

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex #21</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex #21</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1812 Middleborough Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Katie</b> First <b>Kiesling</b> Middle Last				4. DATE OF DEATH <b>July 8, 1960</b> Month Day Year			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 21, 1883</b>	9. AGE (In years last birthday) <b>77</b> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Herman Kiesling</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>5 yrs</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>July 10, 1960</b> , to <b>July 8, 1960</b> , that I last saw the deceased alive on <b>July 8, 1960</b> and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Balto 6 Md</b> DATE SIGNED <b>7/8/60</b>							
ACTUAL SIGNATURE <b>J M Baumgardner</b>				PHYSICIAN'S NAME (Type) <b>Balto 6 Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/11/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt/Carmel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Brudzinski</b> ADDRESS <b>1407 Eastern Ave.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 12 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kiser</b>	

TO HO... OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. 1157RE  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7761 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07736

Reg. Dist No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto</b>	
b. CITY OR TOWN <b>Baltimore--rural</b> and give nearest town		c. LENGTH OF STAY IN 1b <b>Baltimore-rural parkville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2803 Linganore</b>		d. STREET ADDRESS <b>2803 Linganore</b>	
3. NAME OF DECEASED (Type or print) <b>Leonora Maude Kohlhepp</b>		4. DATE OF DEATH Month <b>July</b> Day <b>6</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 25, 1893</b>
9. AGE (In years last birthday) <b>66</b> yrs		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>19</b> Hours <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles W. Hart</b>		14. MOTHER'S MARRIED NAME <b>Hattie Drebing</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>216129089D</b>	
17. INFORMANT <b>Annabelle E Price (cousin)</b>		Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Stroke</b> DUE TO <b>Cerebral vascular Accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>undet</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>undet</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John C Hyle MD</b>		DATE SIGNED <b>7-6-60</b>	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>7-9-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck 5305 Harford Rd.</b>		24a. REC'D BY REGISTRAR <b>11 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Richard J. Keane</b>			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7762

CERTIFICATE OF DEATH

07757

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> , MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. LENGTH OF STAY IN 1b <b>19 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1805 Colonial Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Frances Irene Krickbaum</b>		4. DATE OF DEATH Month Day Year <b>July 13, 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 10, 1874</b>
9. AGE (In years last birthday) <b>86</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Daniels</b>		14. MOTHER'S MAIDEN NAME <b>Jane D. Fernay</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Mrs. Charles Sadler</b>		Address <b>1805 Colonial Rd. (7)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>3 infarctus of age</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1960</b> to <b>July 13, 1960</b> that I last saw the deceased alive on <b>July 12, 1960</b> and that death occurred at <b>12:10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>W. Thos. G. Abbott M.D. 4509 Lehigh Ave. 7-14-60</b>			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type) <b>Thomas G. Abbott</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-16-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Howard Strong</b>		ADDRESS <b>3207 W. North Ave.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 15 '60</b>		24b. REGISTRAR'S SIGNATURE <b>C. L. S. K...</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7763

CERTIFICATE OF DEATH

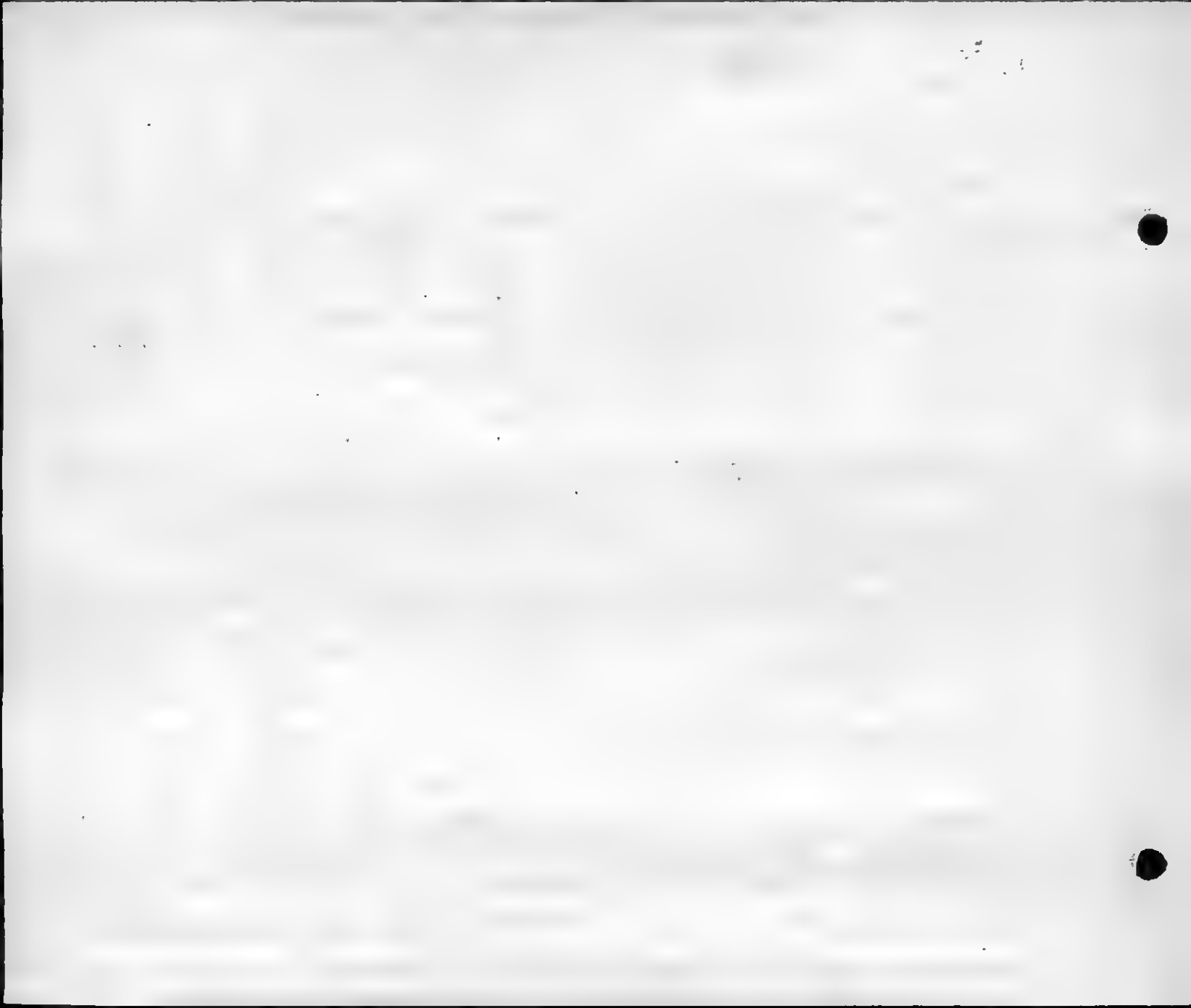
Reg. Dist. No.

07738

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>6</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5107 Kenwood Avenue</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>5107 Kenwood Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Johanna</b> Middle <b>Lachnit</b> Last <b>Lachnit</b>		4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 7, 1871</b>
9. AGE (In years last birthday) <b>88</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Austria</b>	
11. BIRTHPLACE (State or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Gustav Peach</b>		14. MOTHER'S MAIDEN NAME <b>Johanna (unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>John H. Lachnit, Jr., 5107 Kenwood Avenue</b>		Address	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Scurrying Colon</b> DUE TO <b>Polypoid with Metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1960</b> to <b>July 5, 1960</b> , that I last saw the deceased alive on <b>July 5, 1960</b> , and that death occurred at <b>APM</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>2145 W Baltimore St Baltimore, Md</b> DATE SIGNED <b>7/6/60</b>			
ACTUAL SIGNATURE <b>Charles A Cahn</b> M.D.		PHYSICIAN'S NAME (Type) <b>Charles A Cahn</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-8-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DATE JUL 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilrG267 7-8-60 et

## CERTIFICATE OF DEATH

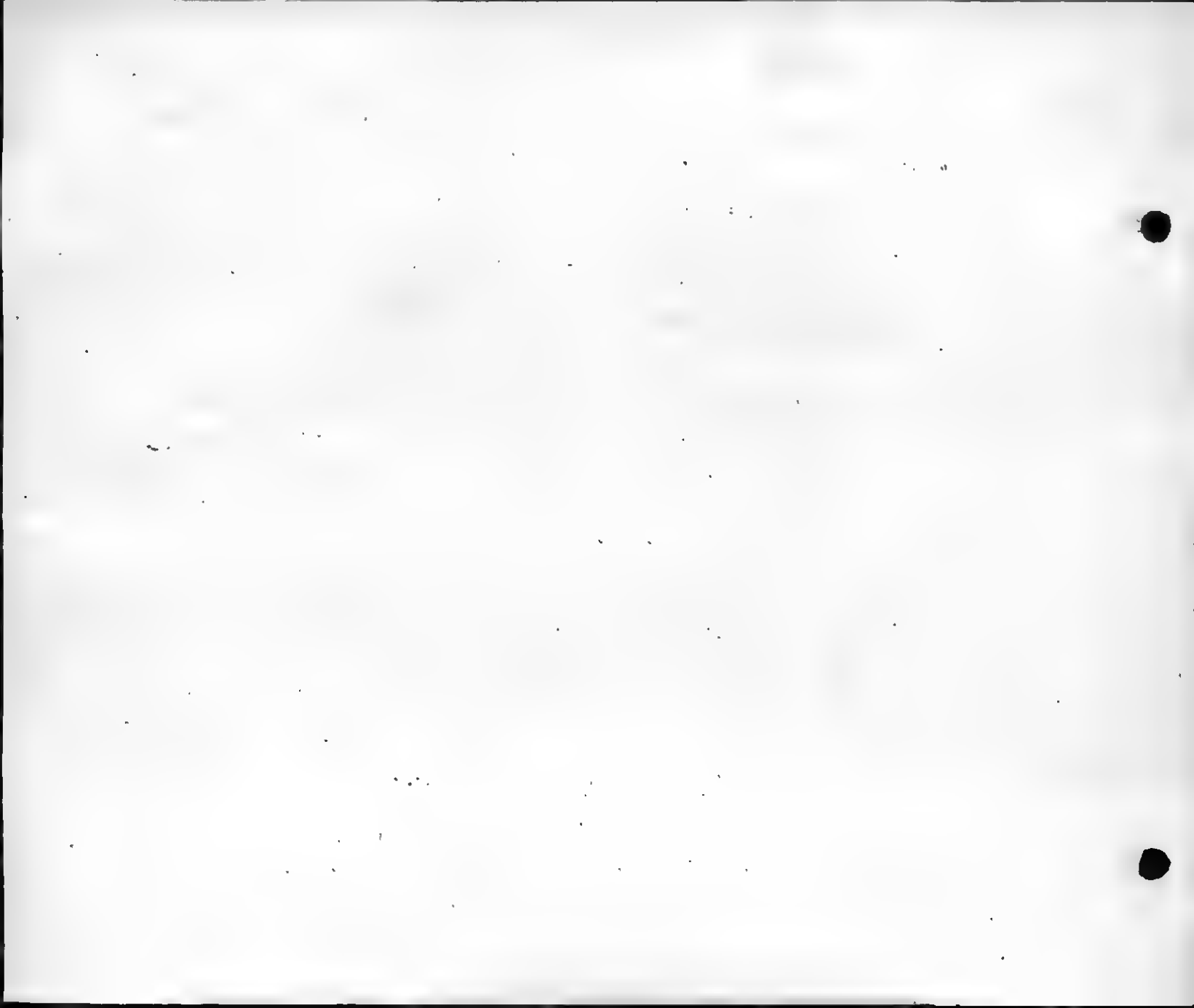
Reg. Dist. **07739**

**7764**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE MANOR</b> c. LENGTH OF STAY IN 1b <b>4.5 YRS.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5947 PRINCE GEORGE ST.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b> d. STREET ADDRESS <b>5947 PRINCE GEORGE ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>SALVATORE SAMUEL LAMAGRO</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>JULY 19 1960</b>			
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>NOV. 3, 1894</b>	
<b>9. AGE</b> (in years last birthday) <b>62 yrs</b>		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min		<b>11. IF UNDER 24 HRS</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>SICILY, ITALY</b>	
<b>13. FATHER'S NAME</b> <b>FRANK LAMAGRO</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>MARY MATARAZZO</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>				<b>16. SOCIAL SECURITY NO</b> <b>212-12-6953</b>			
<b>17. INFORMANT</b> <b>VERNA E. LAMAGRO</b>				<b>Address</b> <b>5947 PRINCE GEORGE ST.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>420</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Coronary artery disease</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary insufficiency - Ischemic</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg. etc.)	
<b>20f. (City or town)</b>				<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that I attended the deceased from</b> <b>195</b> <b>to</b> <b>7/19/60</b> <b>that I last saw the deceased alive on</b> <b>7/19/60</b> <b>and that death occurred at</b> <b>1:35 P.M.</b> <b>from the causes and on the date stated above.</b> <b>ADDRESS</b> (Street, city or town, state) <b>St. John's Professional Center, Ellicott City, Md.</b> <b>DATE SIGNED</b>							
<b>ACTUAL SIGNATURE</b> <b>Christian S. Mass, M. D.</b>							
<b>PHYSICIAN'S NAME (Type)</b> <b>Christian S. Mass, M. D.</b> <b>Ellicott City, Md.</b>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>22b. DATE THEREOF</b> <b>JULY 23, 1960</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>HOLY REDEEMER CEM.</b>		<b>22d. LOCATION (City, town, or county)</b> <b>BALTIMORE, MARYLAND</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Raymond L. Kaczorowski</b>				<b>ADDRESS</b> <b>2525 FLEET ST.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>JUL 25 '60</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kline</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DE: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

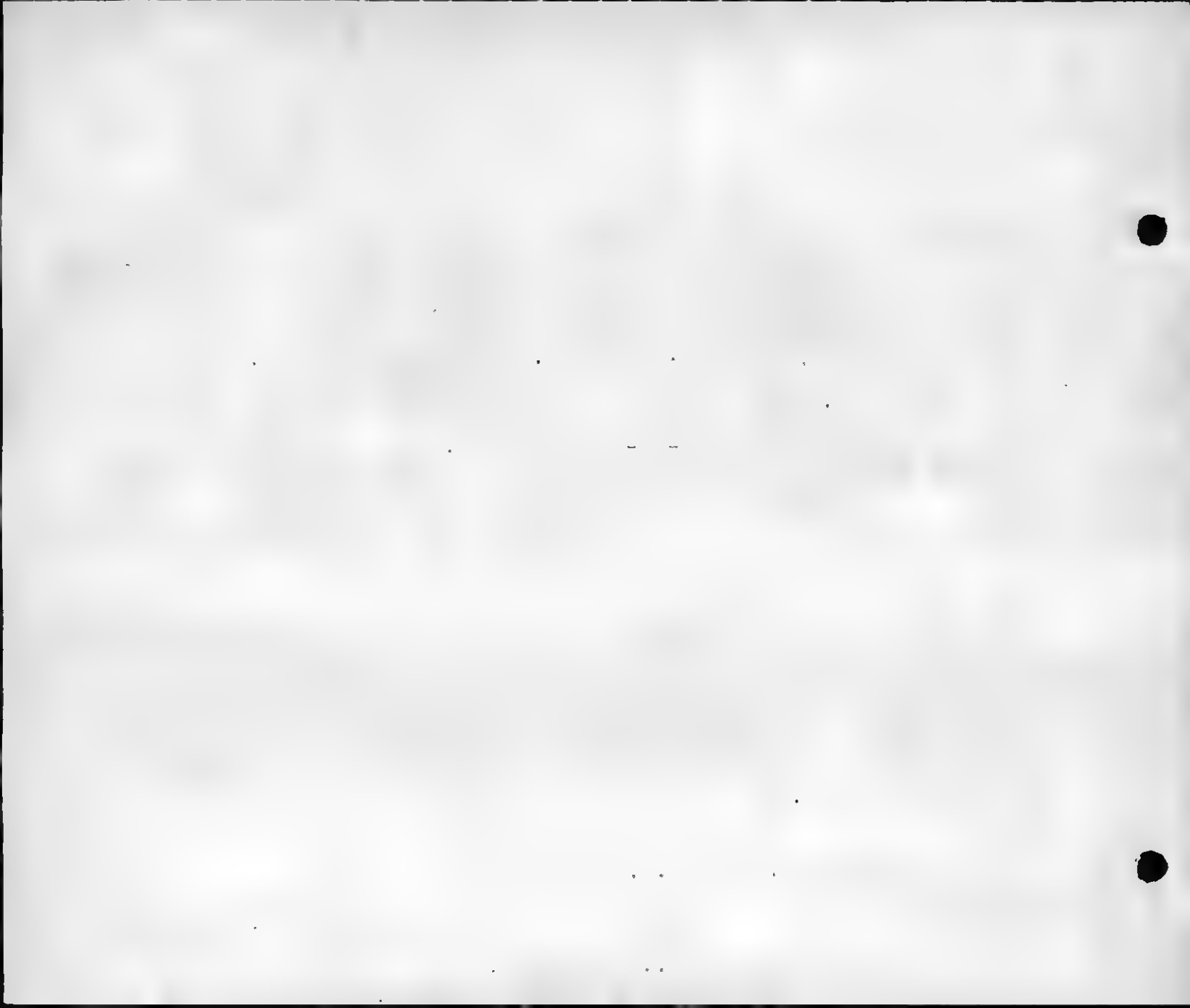
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07740

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>		c. LENGTH OF STAY IN lb <b>19 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk (22)</b>		e. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1947 Walnut Avenue</b>				d. STREET ADDRESS <b>1947 Walnut Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>CHARLES</b> Last <b>LANGE</b>				4. DATE OF DEATH Month <b>July</b> Day <b>30th</b> Year <b>1960</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 25, 1892</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b></b> Days <b></b>		11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Master Sergeant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>		11. BIRTHPLACE (State or foreign country) <b>Michigan</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Charles F. Lange</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Stegemann</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>WWI</b>				16. SOCIAL SECURITY NO. <b>218-22-0253</b>		17. INFORMANT <b>Anna C. Lange</b> Address <b>same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>023X</b> DUE TO <b>Acute Aortitis + Myocarditis =</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>with Aortic insufficiency + Stenosis</b> DUE TO (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>M B Davis</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8/1/60</b>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/3/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc., Dundalk 22, Md</b>				24a. REC'D BY REGISTRAR <b>DATE AUG 2 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07741

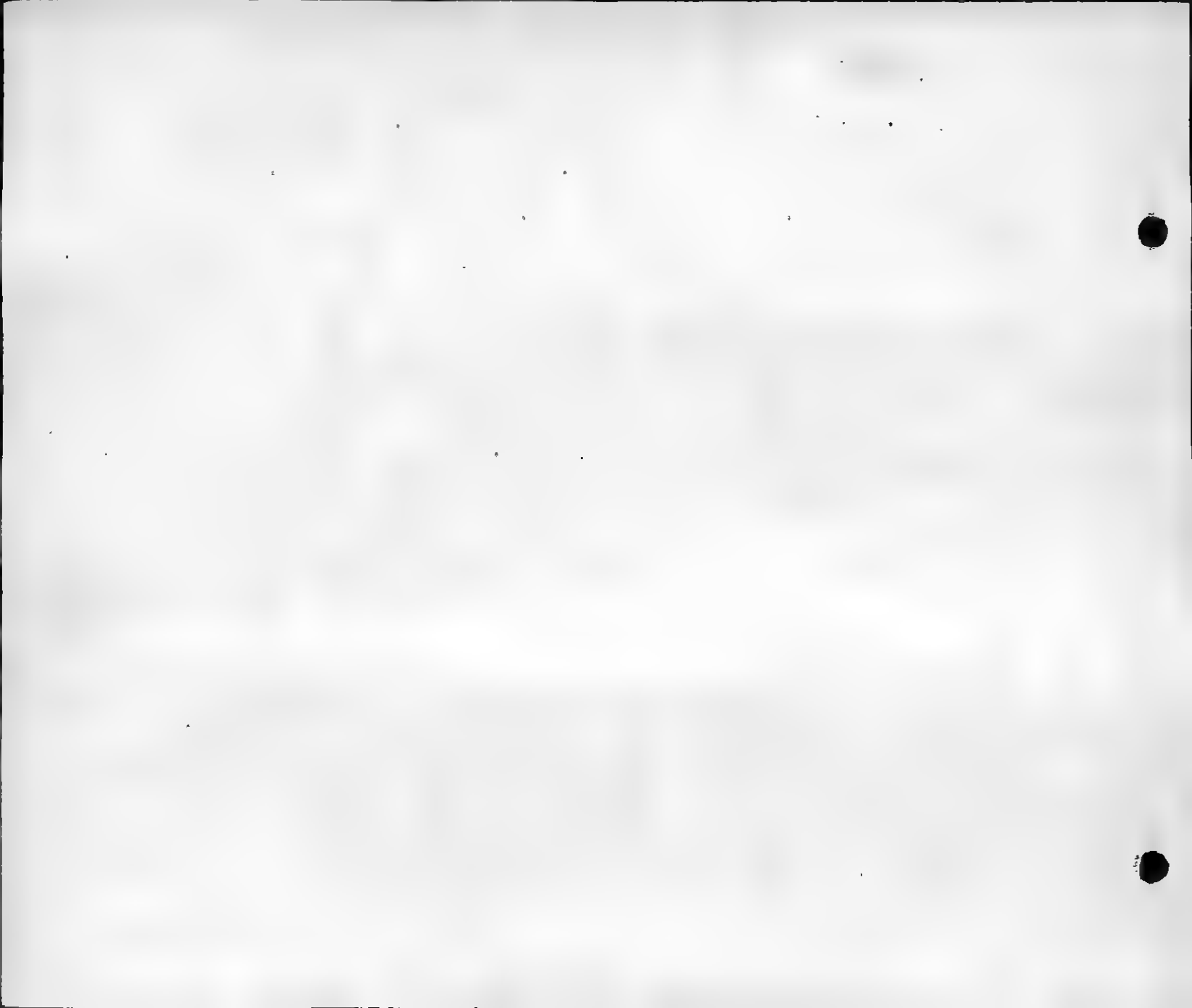
7765

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Ma.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pilesville</u>		c. LENGTH OF STAY IN 1b <u>21 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pilesville, Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12 Dreher Ave. Pilesville, Md.</u>				d. STREET ADDRESS <u>12 Dreher Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Alfred S. Johnson, Jr.</u>				4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1860</u>		9. AGE (in years last birthday) <u>20</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>  </u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Zimmerman Ice Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Milburn Lewis</u>				14. MOTHER'S MAIDEN NAME <u>  </u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>212-14-2106A</u>		17. INFORMANT <u>Pilesville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured R. Hip</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>  </u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Motor vehicle accident in car garage.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> <u>June 27, 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>Pilesville, Baltimore, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
SIGNATURE <u>D.D. Johnson, M.D.</u> EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>  </u>		22b. DATE THEREOF <u>July 15, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shaw Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>				REC'D BY REGISTRAR <u>  </u> DATE <u>JUL 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
7766

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07742

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore-Rural</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady Nook Nursing Home 1002 N. Rolling Road</b>				d. STREET ADDRESS <b>208 Brookfield Road</b>			
e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>S.</b> Last <b>LIPSCOMB, SR.</b>				4. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 14, 1874</b>	9. AGE (In years last birthday) <b>85</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		11. BIRTHPLACE (State or foreign country) <b>Richmond, Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Winfield Lipscomb</b>				14. MOTHER'S MAIDEN NAME <b>Octavia Parsley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>Spanish Amer. None</b>		17. INFORMANT <b>Mrs. Mary McNutt-208 Brookfield Road-Pasadena, Md.</b>			
18. CAUSE OF DEATH [Enter on any one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho Pneumonia</b> 541 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary Embolus</b> DUE TO (c) <b>Duodenal Ulcer - Arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b> <b>3 Days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 1960</b> to <b>July 1, 1960</b> that (I) <del>was</del> last saw the deceased alive on <b>June 30, 1960</b> and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>Wm. J. Teebner</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7-2-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Wetherbee Fort</b>		22d. ADDRESS <b>1118 St. Paul St. Baltimore</b>					
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/4/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Teebner</b>				25a. REC'D BY REGISTRAR <b>Jul 5 1960</b>		25b. REGISTRAR'S SIGNATURE <b>Wm. J. Teebner</b>	
ADDRESS <b>Baltimore 17, Md.</b>							



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7767 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07743

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE RURAL</b> c. LENGTH OF STAY IN 1b <b>BALTIMORE RURAL (ROSEDALE)</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE RURAL (ROSEDALE)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>811 1/4 Rosedale Avenue</b>		d. STREET ADDRESS <b>811 1/4 ROSEDALE</b>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>E</b> Last <b>LUPUS</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>14</b> Year <b>19 60</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>21 APRIL 1887</b>
9. AGE (In years last birthday) <b>73</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sheet Metal</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Lupus</b>		14. MOTHER'S MAIDEN NAME <b>Laura Weigler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>215-05-8507</b>	
17. INFORMANT <b>Mrs. Lena Lupus</b>		Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION &amp; MYOCARDIAL INFARCTION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John C. Hyle</b>		DATE SIGNED <b>7-14-60</b>	
EXAMINER'S NAME (Type) <b>John C Hyle MD</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/16/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		ADDRESS <b>5305 Harford Road #14</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 18 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knead</b>	

TO DEPENDENT: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further action is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Item 18 Film 267 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7-15-60 ans. 7768 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07744

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>3 hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hosp.</b>				d. STREET ADDRESS <b>1206 Townson St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>L.</b> Last <b>Mc Burney</b>				4. DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-13, 1896</b>		9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Albert Mc Burney</b>				14. MOTHER'S MAIDEN NAME <b>Mollie ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Army</b>		17. INFORMANT <b>Record of Hospital</b> Address <b>Catonsville Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pending/ Cardiac failure</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio vascular disease</b> DUE TO (c) <b>Acute cirrhosis of liver</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Geo. S. M. Kieffer M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Geo. S. M. Kieffer M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>July 4, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>7-1-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		22d. LOCATION (City, town, or county) (State) <b>Green Mount</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. E. Gandy</b>				24a. REC'D BY REGISTRAR <b>UL 5 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	



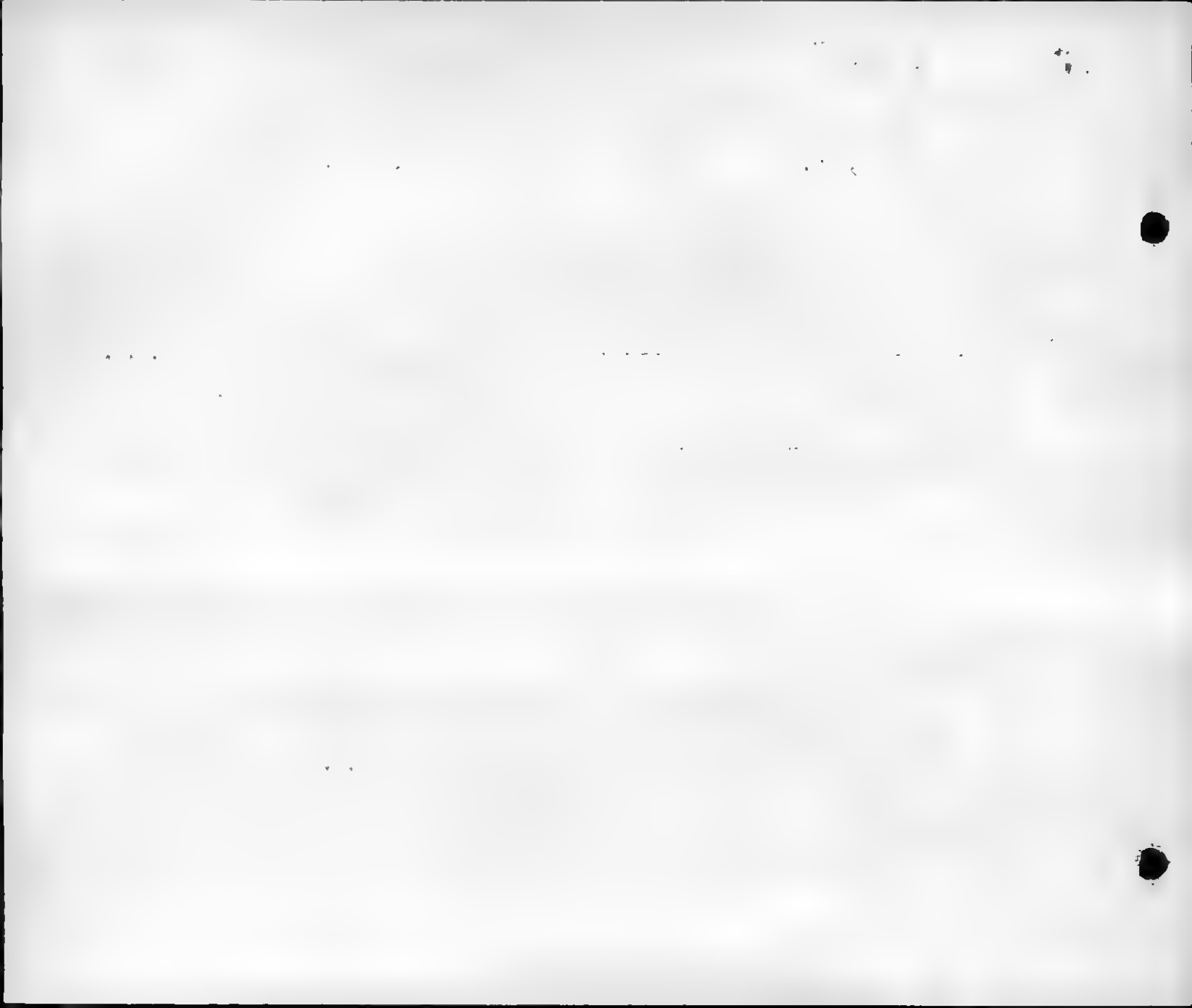
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7769

07745

1. PLACE OF DEATH <u>Rosewood State Training School</u>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)			
a. COUNTY <u>Baltimore</u> MARYLAND				a. STATE <u>Maryland</u> b. COUNTY <u>Monkton</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton, Maryland</u>			
c. LENGTH OF STAY IN 1b <u>3 1/2 months</u>				d. STREET ADDRESS <u>Corbett Road</u>			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>Rosewood State Training School</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Burns McCloskey</u>				4. DATE OF DEATH Month Day Year <u>7 5 19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/12/59</u>	
9. AGE (In years last birthday) yrs <u>6</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>6</u>		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>Maryland - Baltimore City</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James McCloskey</u>				14. MOTHER'S MAIDEN NAME <u>Carolyn Louise McCloskey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Rosewood Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia due to aspiration</u>							
344X DUE TO (b) <u>of stomach content complicating</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>hydrocephalus and meningitis myeloma</u>							
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that death occurred at <u>1:40 p.m.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Peter W. Rieckert, Pathologist</u>				22b. ADDRESS <u>4207 Mainfield Ave, Baltimore 14, Md</u>			
22c. PHYSICIAN'S NAME (Type) <u>Peter W Rieckert</u>				22d. ADDRESS <u>4207 Mainfield Ave, Baltimore 14, Md</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 8 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rosewood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Owings Mills Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Elmer Sons Rustinstown</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 11 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur J. Howard</u>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



7770

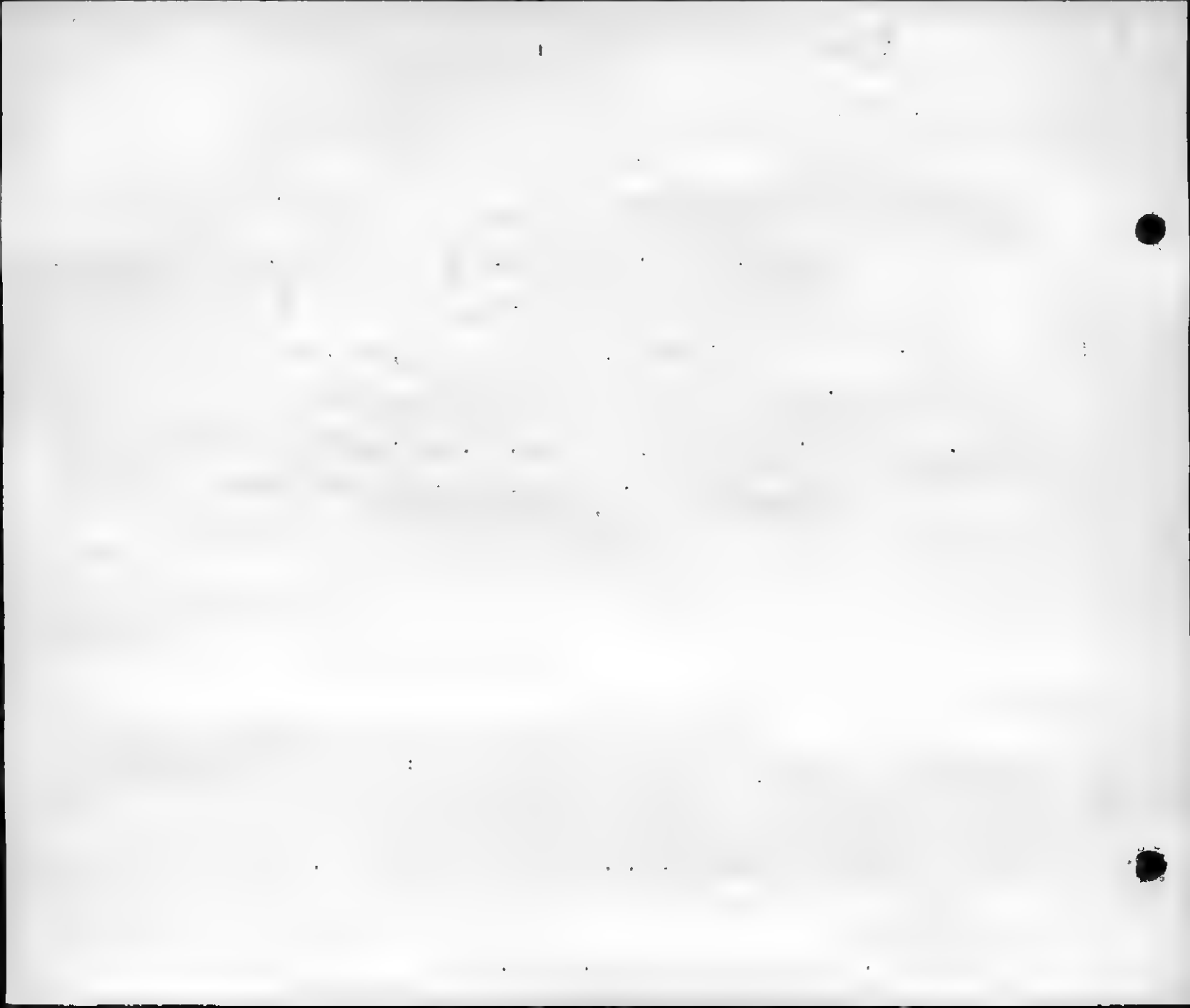
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07746

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>1</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>32 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>8249 BULLNECK ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>ARTHUR</b> Middle <b>----</b> Last <b>McCLYMONT</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>29</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 1, 1895</b>
9. AGE (In years lost birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>65</b> Days <b>65</b> Hours <b>65</b> Min <b>65</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION CO</b>	
11. BIRTHPLACE (State or foreign country) <b>OAKRIDGE, NEW JERSEY</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM McCLYMONT</b>		14. MOTHER'S MAIDEN NAME <b>CARRIE (UNKNOWN)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO <b>215-24-5742</b>	
17. INFORMANT <b>CLIN. REC. VAH BALTO 18, MD FT HOWARD DIVISION</b>		Address <b>CLIN. REC. VAH BALTO 18, MD FT HOWARD DIVISION</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA STOMACH WITH METASTASES TO REGIONAL LYMPH NODES, LIVER AND LUNGS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>UNKNOWN</b> (c) <b>UNKNOWN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Edema of the lungs</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 27 8:05 AM</b> to <b>July 29 1960</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 29 1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter J. Pijanowski</b> M.D.		22b. DATE <b>7/29/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER J. PIJANOWSKI, M.D.</b>		22d. ADDRESS <b>VAH Balto 18, Md., Ft Howard Division</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>AUG 1, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>C. F. Hoffman</b> ADDRESS <b>Clarence F. Hoffman 3218 Hudson St. Balto, Md</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 1 '60</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

M

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

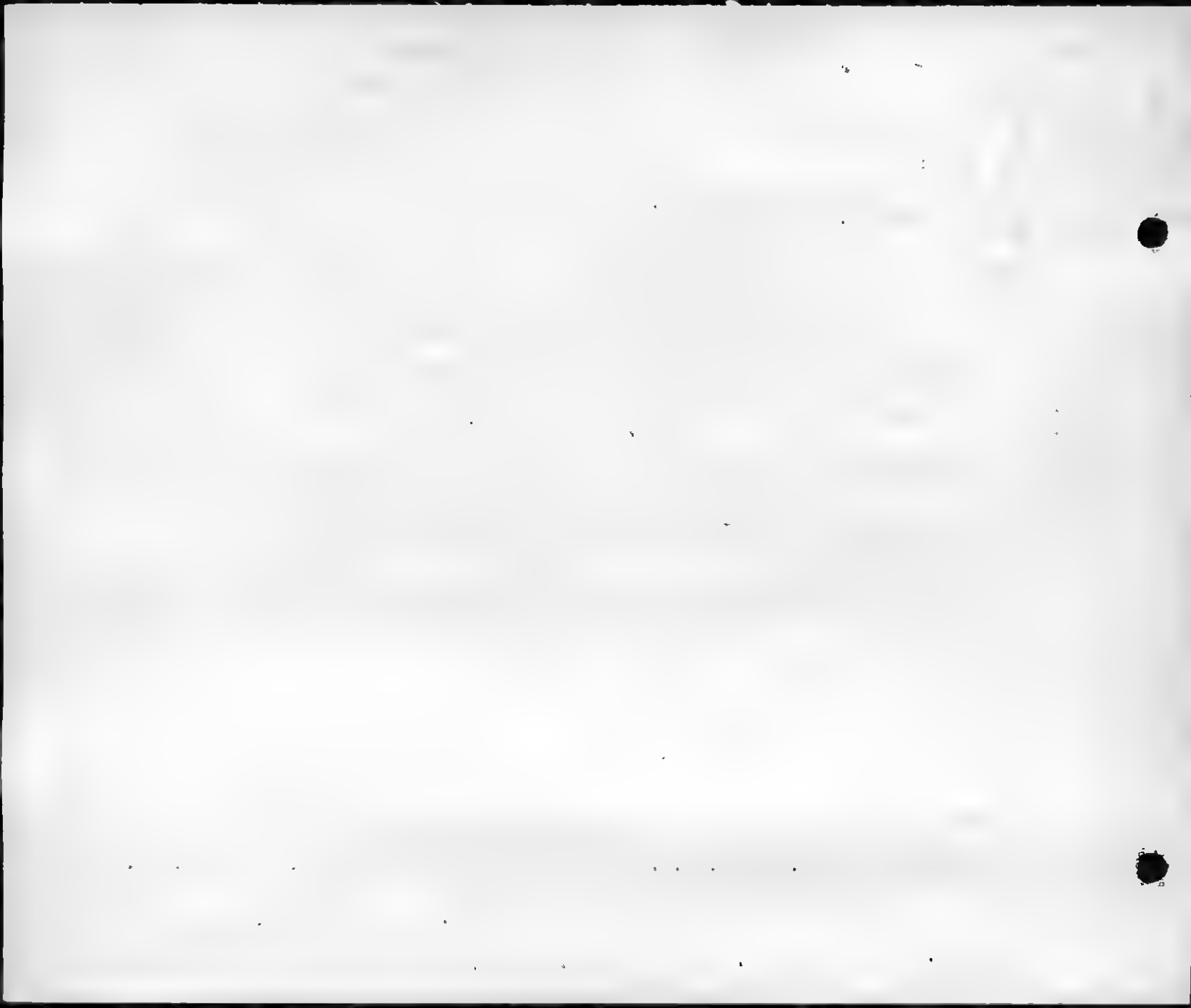
7771

## CERTIFICATE OF DEATH

Reg. Dist. No. 07747

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural: Towson 4</b>		c. LENGTH OF STAY IN 1b <b>13 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eudowood Sanatorium, Towson 4, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Miles</b> Middle <b>Joseph</b> Last <b>McCourt</b>		4. DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>1960</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/25/86</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Blacksmith</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore City</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Charles McCourt</b>		14. MOTHER'S MAIDEN NAME <b>Mary McCall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-18-1151</b>	
17. INFORMANT <b>Personal History</b>		Address <b>Eudowood Sanatorium</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>Carcinoma of Prostate with cerebral metastases &amp; cerebral thrombosis</b>			
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 29, 1959</b> to <b>July 3, 1960</b> , that I last saw the deceased alive on <b>June 29, 1960</b> , and that death occurred at <b>9:10 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Milton B. Kress, M.D.</b>		ADDRESS (Street, city or town, state) <b>Eudowood Sanatorium</b>	
DATE SIGNED <b>7/5/60</b>			
PHYSICIAN'S NAME (Type) <b>Milton B. Kress, M.D.</b>			
ADDRESS <b>Eudowood Sanatorium, Towson 4, Md.</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 6, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Abron</b>		ADDRESS <b>3000 E. Baltimore St., Balto.</b>	
24a. REC'D BY REGISTRAR <b>JUL 7 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

Page 4  
2 years after death  
The low requires that the death certificate be executed within 2 years after death  
may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7772

## CERTIFICATE OF DEATH

Reg. Dist. No.

07748

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>?</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>348 Westshire Road</b>		e. STREET ADDRESS <b>348 Westshire Road</b>	
3. NAME OF DECEASED (Type or print) <b>Marjorie R. Mc Dowell</b>		4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 8, 1885</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jeremiah Gossard</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Wassen</b>	
15. WAS DECEASED EVER IN U. S. ARMED SERVICES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>216.12.6822A</b>	
17. INFORMANT <b>Mrs. Elizabeth Shettle</b>		Address <b>348 Westshire</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Rupture abdominal aneurysm</b> DUE TO <b>Atherosclerosis, abdominal aorta</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>years</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive Cardiovascular Disease</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 7/4</b> , 19 <b>60</b> , to <b>7/5</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>7/4</b> , 19 <b>60</b> , and that death occurred at <b>4:15A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James J. Nolan</b>		ADDRESS (Street, city or town, state) <b>1 Mallory Hill Ave, Baltimore, Md.</b>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/8/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Stansbury</b>		ADDRESS <b>6411 Windsor Mill Rd.</b>	
24a. REC'D BY REGISTRAR <b>JUL 7 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used if needed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

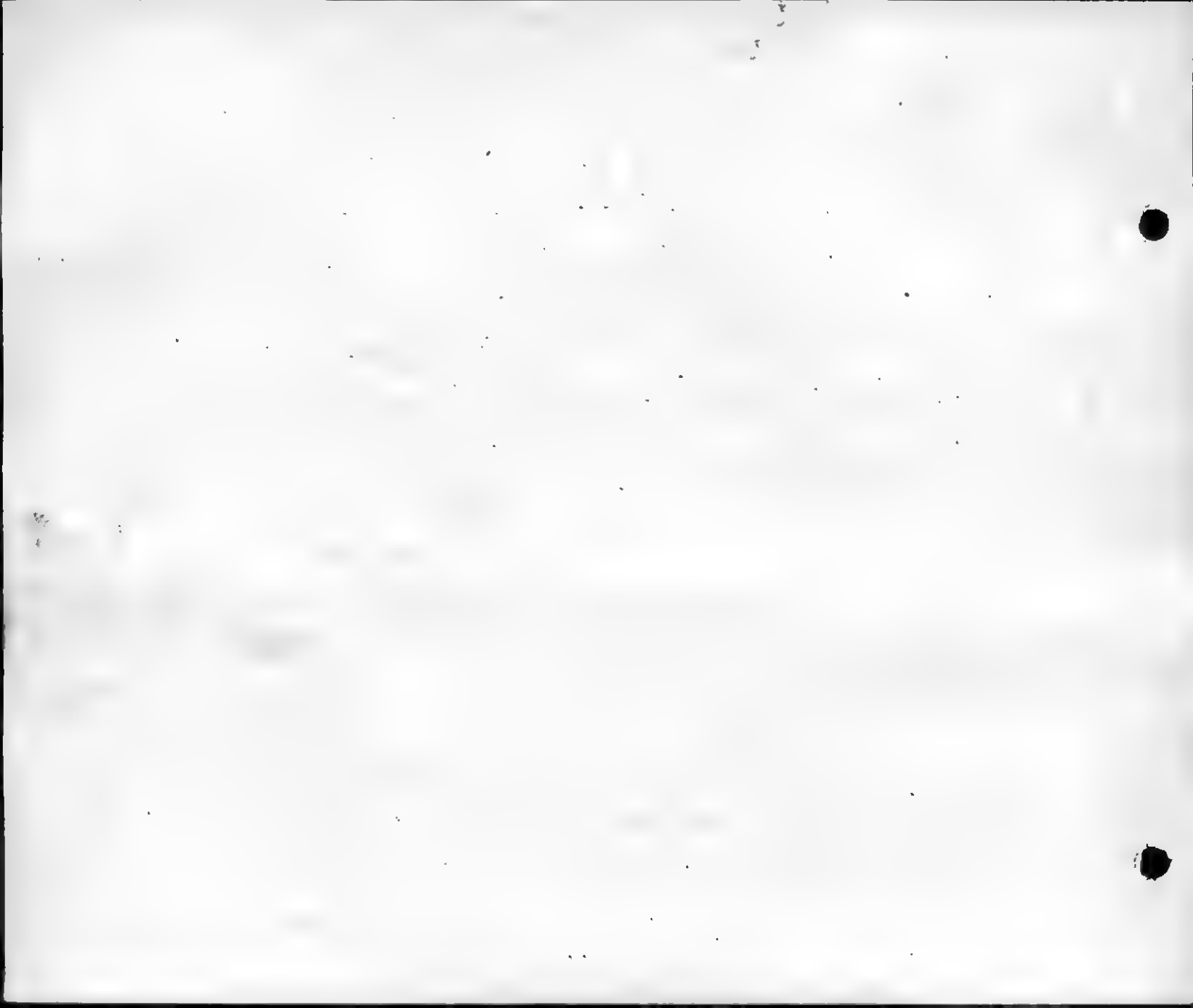
7773

## CERTIFICATE OF DEATH

Reg. Dist. No. 07749

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville 4</i>		c. LENGTH OF STAY IN 1b <i>6 mo.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>College Manure Aged Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>Bessie Pearl McEimmis</i>		4. DATE OF DEATH <i>July 25 1960</i>	
5 SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-15-1875</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>
13. FATHER'S NAME <i>Thomas E. McCready</i>		14. MOTHER'S MAIDEN NAME <i>Mollie Harris</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>INFORMANT</i> Address <i>Mr. J. Calvin Carney, Jr.-3 E. Lexington Street</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma Rectum.</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>15-25</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Mar. 2, 1957, to July 25, 1960</i> that I last saw the deceased alive on <i>July 23, 1960</i> , and that death occurred at <i>7:45 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George F. Shannon</i> M.D.		ADDRESS (Street, city or town, state) <i>412 Medical Arts Bldg</i> DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>George F. Shannon</i>		<i>Baltimore, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/28/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Pikesville, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Pickens</i> ADDRESS <i>Baltimore - 17. Md.</i>		24a. REC'D BY REG STRAR DATE <i>JUL 27 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kinn</i>

TO HOSTS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



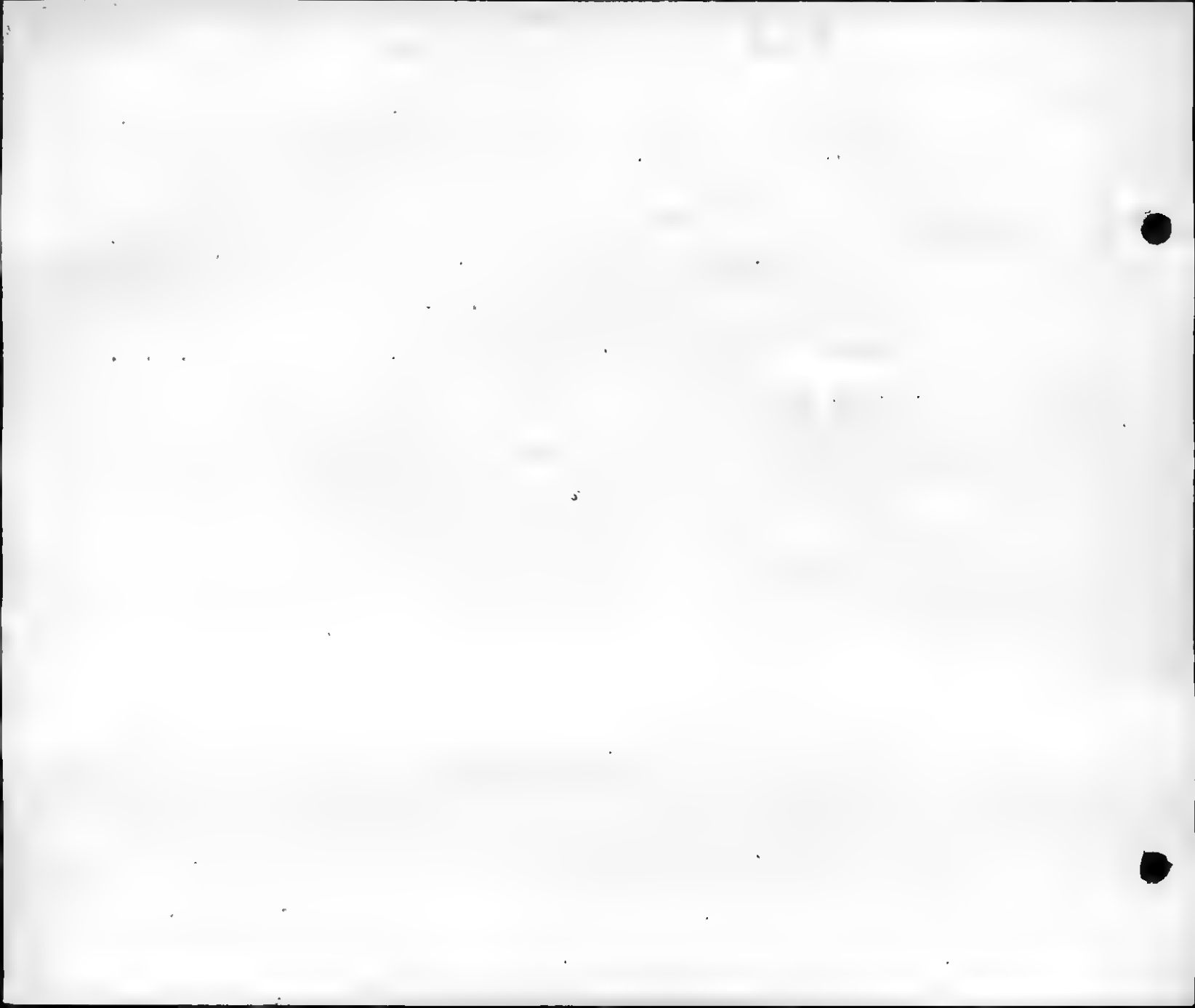
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**7774**  
**CERTIFICATE OF DEATH**

07750

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float:right">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN lb <u>3yr1mth2dys</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt, Maryland</u> d. STREET ADDRESS <u>14 South Hillside Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Harry Byers McNeel</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>July 1, 1960</u> 19	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Sept. 11, 1892</u>		9. AGE (In years last birthday) <u>67</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Erco Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Sanford Mc Neel</u>		14. MOTHER'S MAIDEN NAME <u>Ora Byers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Circulatory cardiovascular disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 16</u> , 1960, to <u>7/1</u> , 1960, that I last saw the deceased alive on <u>7/1</u> , 19 <u>60</u> , and that death occurred at <u>6:50 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Anthony S. Garofano</u> M.D.		<u>SPRING GROVE STATE HOSPITAL</u>	
PHYSICIAN'S NAME (Type) <u>Anthony S. Garofano</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 5, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Geo Washington Cemetery - Hyattsville Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 5 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

7775

Item 12 Film G-67 7-29-60 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

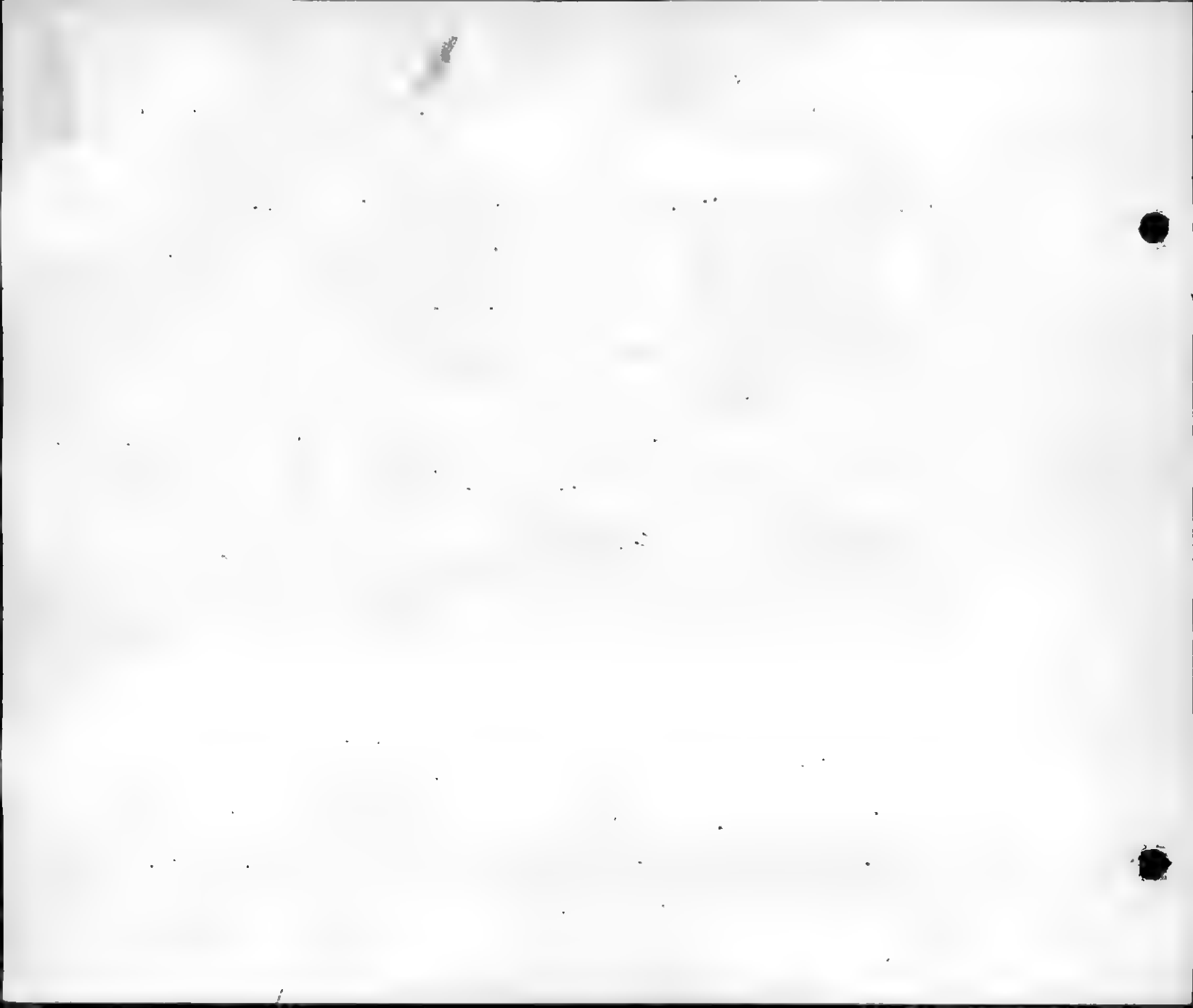
CERTIFICATE OF DEATH

Reg. Dist. No. 07751

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm ssion) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6416 Frederick Ave.</b>		e. STREET ADDRESS <b>6416 Frederick Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Megna</b> Last <b>Megna</b>		4. DATE OF DEATH Month <b>July</b> Day <b>17</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 29, 1872</b>
9. AGE (In years last birthday) yrs. <b>88</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Sicily</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Raphael Morgavi</b>		14. MOTHER'S MAIDEN NAME <b>Sara -----</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>--</b>		16. SOCIAL SECURITY NO <b>--</b>	
INFORMANT <b>Mrs. Stephen Provenza</b>		Address <b>6416 Fred. Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary Embolism</b> DUE TO <b>Pericarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Post-operative hernia 6/1948</b> DUE TO (c) <b>12 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/5</b> , 19 <b>58</b> , to <b>7/17</b> , 19 <b>60</b> that I last saw the deceased alive on <b>7/16</b> , 19 <b>60</b> , and that death occurred at <b>6 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James W. Katzenberger</b> M.D.		ADDRESS (Street, city or town, state) <b>4123 Frederick Ave Balto MD</b> DATE SIGNED <b>7/20/60</b>	
PHYSICIAN'S NAME (Type) <b>JAMES W. KATZENBERGER</b>		<b>4123 FREDERICK AVE BALTO MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-21-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Farley Funeral Home, Catonsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 25 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7776

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b>		c. LENGTH OF STAY IN 1b <b>White Marsh</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady Nook Nursing Home 1002 N. Rolling Rd</b>		e. STREET ADDRESS <b>White Marsh</b>	
3. NAME OF DECEASED (Type or print) First <b>Milton</b> Middle <b>C.</b> Last <b>Merryman</b>		4. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 14, 1884</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George C. Merryman</b>	
14. MOTHER'S MAIDEN NAME <b>Katherine (unknown)</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Jeanette Sloman, 615 Luzerne Avenue</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> DUE TO <b>112.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchogenic Carcinoma</b> DUE TO <b>Lung.</b> (c) <b>Lung.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b> <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2/16</b> 19 <b>60</b> to <b>July 21</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>July 26</b> , 19 <b>60</b> , and that death occurred at <b>5:15 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William H. Cook, Inc.</b> M.D. <b>1118 St. Paul St.</b>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Brother Bee Tort</b>		<b>Baltimore 27th</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>7-30-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wm. Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 29 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SMC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

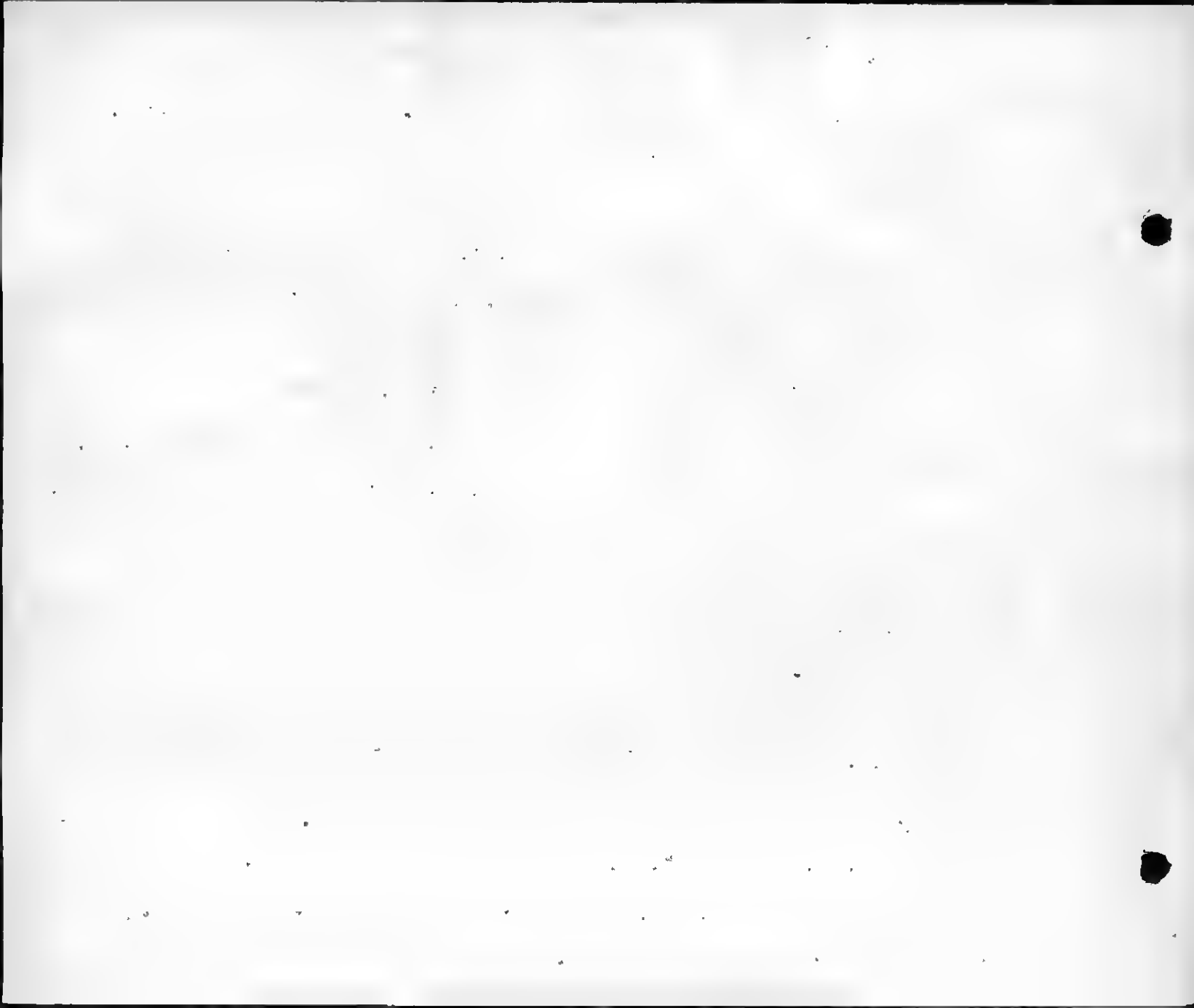
7777

## CERTIFICATE OF DEATH

07753

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>10 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrison Forest Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Emory</b> Last <b>Michael</b>		4. DATE OF DEATH Month <b>July</b> Day <b>21</b> , Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 11, 1877</b>
9. AGE (In years last birthday) yrs. <b>82</b>		10. IF UNDER 1 YEAR Months <b>82</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George H. Michael</b>		14. MOTHER'S MAIDEN NAME <b>Mary C. Leonard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Ella W. Michael</b>		Address <b>Owings Mills, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic C.-V. Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>20 yrs.</b> (c) <b>20 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRARY TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Portal Cirrhosis- Hernia</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>none</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I attended the deceased from <b>5-20-40</b> , 19 <b>40</b> , to <b>7-21-60</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>7-19-60</b> , 19 <b>60</b> , and that death occurred at <b>7 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>D. D. Caples</b>		DATE SIGNED <b>7-21-60</b>	
PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>		ADDRESS (Street, city or town, state) <b>6 Hanover Rd. Reisterstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 23, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Charles Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Pikesville Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Eline &amp; Sons</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 25 '60</b>	
ADDRESS <b>Reisterstown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>C. J. P. Jones</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7683

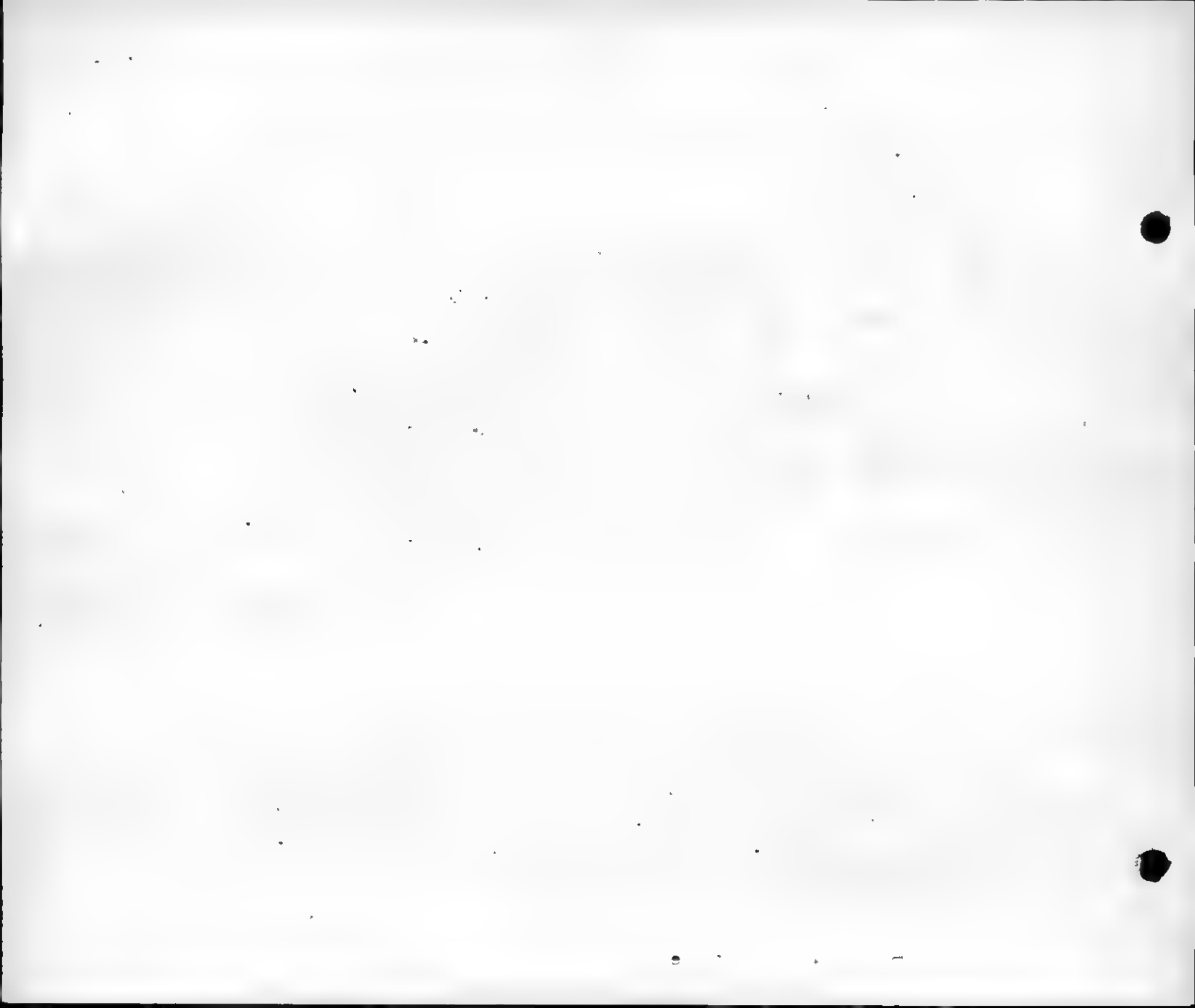
## CERTIFICATE OF DEATH

Reg. Dist. No. 07754

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>522 Delores Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET M.</b> Middle <b>WILLER</b> Last		4. DATE OF DEATH <b>7/28/60</b> Month Day Year	
5 SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/17/90</b>
9 AGE (In years last birthday) yrs. <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>INFORMANT</b> Address <b>Family - Same</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Hypertensive CVD</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>12 hr.</b> <b>? yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 10, 1960</b> to <b>July 28, 1960</b> that I last saw the deceased alive on <b>July 28, 1960</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Herbert J. Levickas M.D. 5305 East Drive 7/29/60</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>Herbert J. Levickas Baltimore - 27, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>	22b. DATE THEREOF <b>8/1/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>McGully - 130 E. Port Avenue</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 2 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



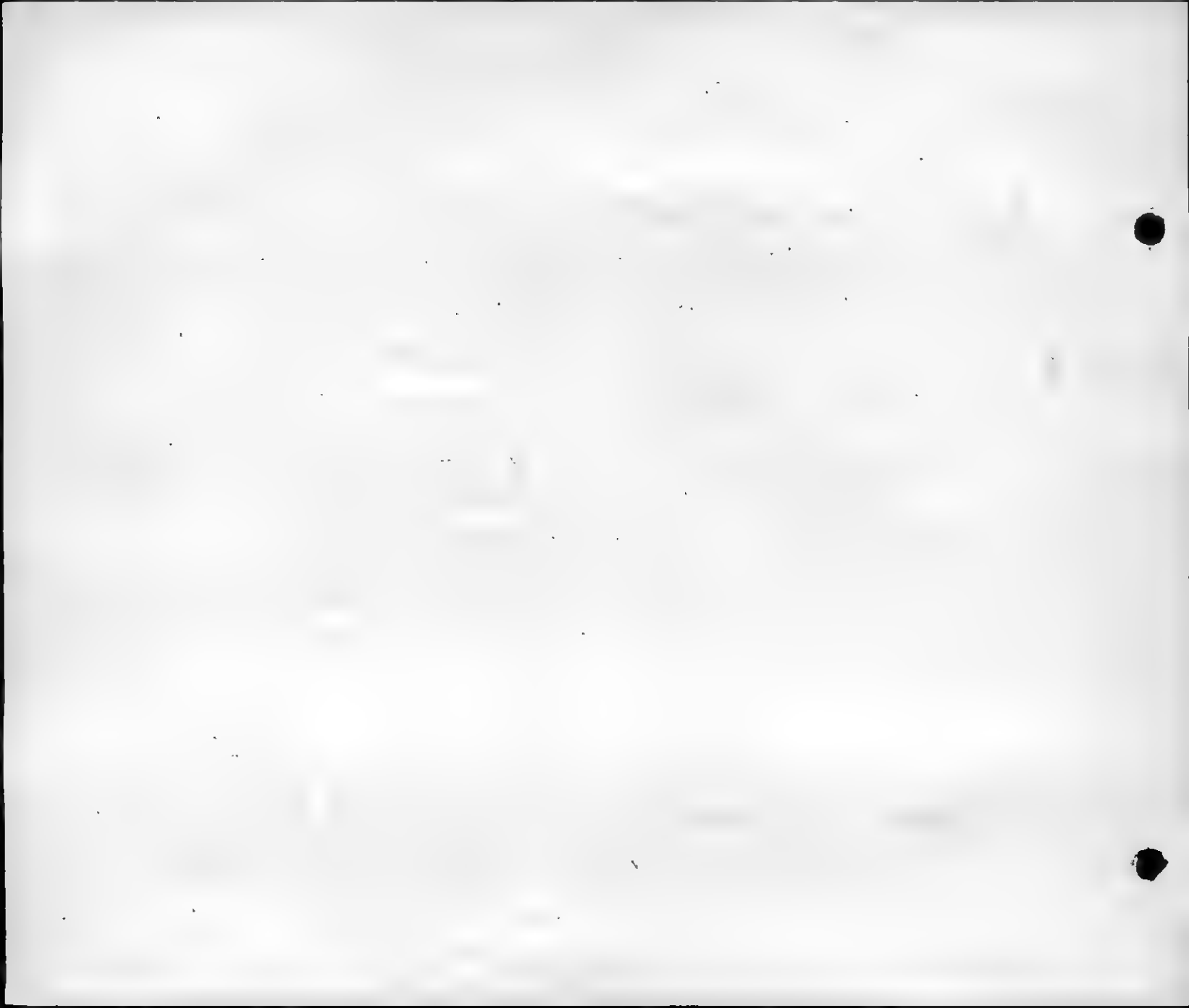
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

77778

07755

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stonleigh</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stonleigh</u>	
3. NAME OF DECEASED (Type or print) <u>MARGARET A MITCHELL</u> First Middle Last		4. DATE OF DEATH <u>July 5 1960</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20 1870</u> 9. AGE (In years last birthday) <u>90</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Upper Fairmount, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Sudler</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Waters</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <u>no</u> (If yes, give war or dates of service, <u>—</u> )		16. SOCIAL SECURITY NO <u>no</u>	
17. INFORMANT <u>Mrs. J. Larkin Gorsuch</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 10 1950</u> to <u>July 5 1960</u> that (I) <u>met</u> last saw the deceased alive on <u>July 5 1960</u> and that death occurred on <u>July 5 1960</u> at <u>3:10 A</u> M. from the causes and on the date stated above			
22a. SIGNATURE <u>Laurence C. Post</u> 22b. PHYSICIAN'S NAME (Type) <u>LAURENCE C. Post</u>		22c. ADDRESS <u>6805 York Rd. Baltimore 12 Md</u>	
23a. BLR AL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 8, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Pocomoke City Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins &amp; Sons Co.</u>		25a. REC'D BY REGISTRAR <u>DATE JUL 8 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7779

07756

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary(s)</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2mth16dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>none</b>	
3. NAME OF DECEASED (Type or print) <b>William Lee Morgan</b>		4. DATE OF DEATH Month <b>July</b> Day <b>11</b> Year <b>19 60</b>	
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>June 21, 1895</b>
9 AGE (In years lost birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11 BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Morgan</b>		14. MOTHER'S MAIDEN NAME <b>Jeanette Burch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>220-32-5977</b>	
17 INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18 CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).}			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> 422.1 DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>July 5</b> 19 <b>60</b> to <b>July 11</b> 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>July 11</b> 19 <b>60</b> , and that death occurred on <b>July 11</b> 19 <b>60</b> , from the causes and on the date stated above			
22a. SIGNATURE <b>Stella Wachslar, M. D.</b>		22b. DATE SIGNED <b>7-11-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/14/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>	23d. LOCATION (City, town, or county) (State) <b>Bushwood, Maryland</b>
24 FUNERAL DIRECTOR'S SIGNATURE <b>M. Clarke Mattingly, Leonard Town, Md.</b>		25a. REC'D BY REG-STRAR DATE <b>JUL 13 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

(M)

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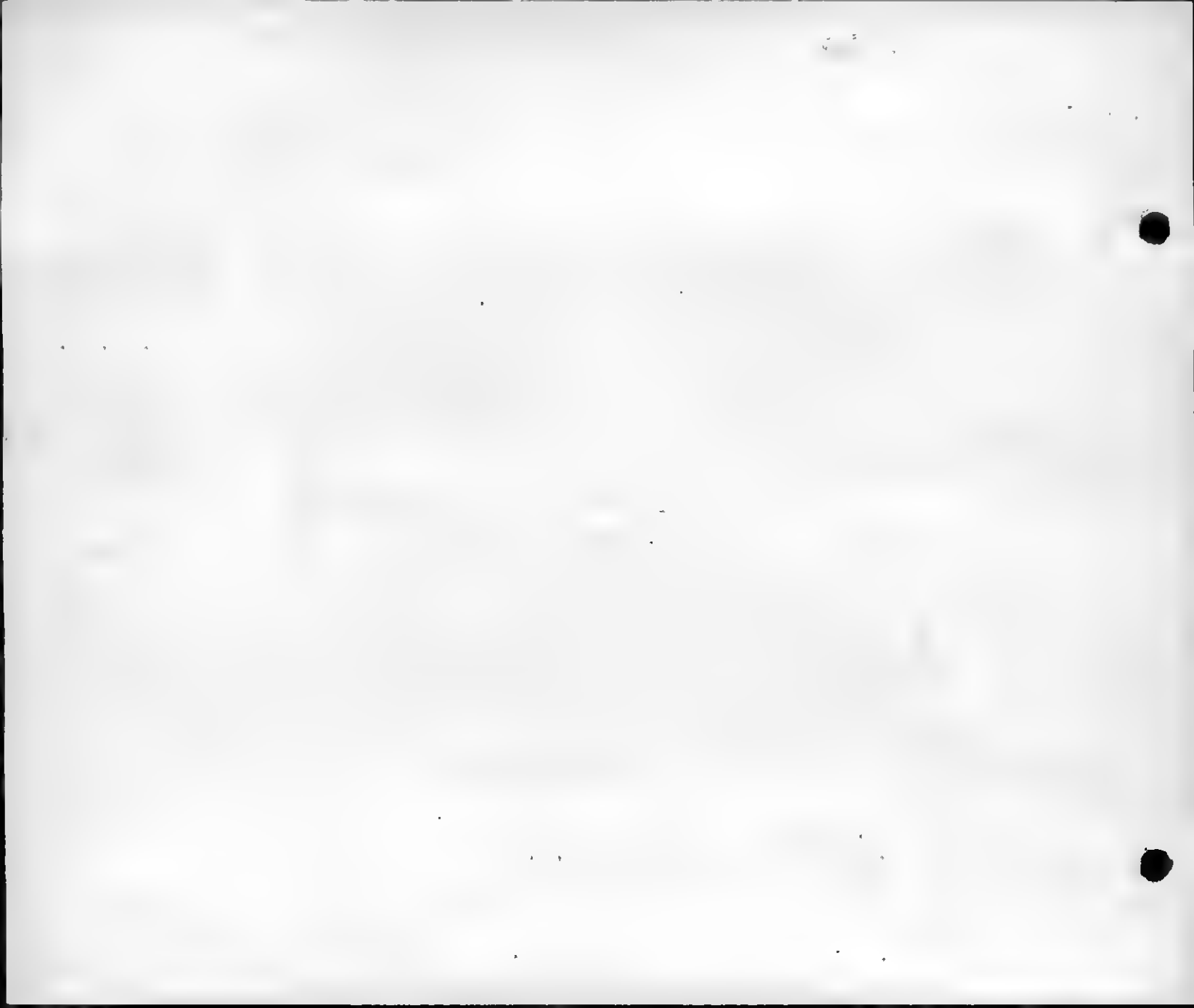
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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7780  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07752

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5103 Leeds Avenue</b>		d. STREET ADDRESS <b>5103 Leeds Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Mueller</b> Last <b>Mueller</b>		4. DATE OF DEATH Month <b>July</b> Day <b>22</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 15, 1891</b>
9. AGE (In years last birthday) <b>69</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>22</b> Days <b>22</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Keller</b>		14. MOTHER'S MAIDEN NAME <b>Francisca Fritch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-30-3893B</b>	
17. INFORMANT <b>B. Henry Mueller</b>		Address <b>5103 Leeds Avenue #27</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Atherosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>3 yrs</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat white <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 24, 1957</b> to <b>July 22, 1960</b> that (I) (we) last saw the deceased alive on <b>July 22, 1960</b> , and that death occurred at <b>6:24</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>A. Bradley</b>		22b. DATE SIGNED <b>7-22-60</b>	
22c. PHYSICIAN'S NAME (Type or print) <b>A. Bradley</b>		22d. ADDRESS <b>1264 Francis Avenue</b>	
22e. M. D.		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/25/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Elkridge, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		24a. REC'D BY REGISTRAR <b>JUL 25 '60</b>	
ADDRESS <b>4107 Wilkens Ave.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



7781

## CERTIFICATE OF DEATH

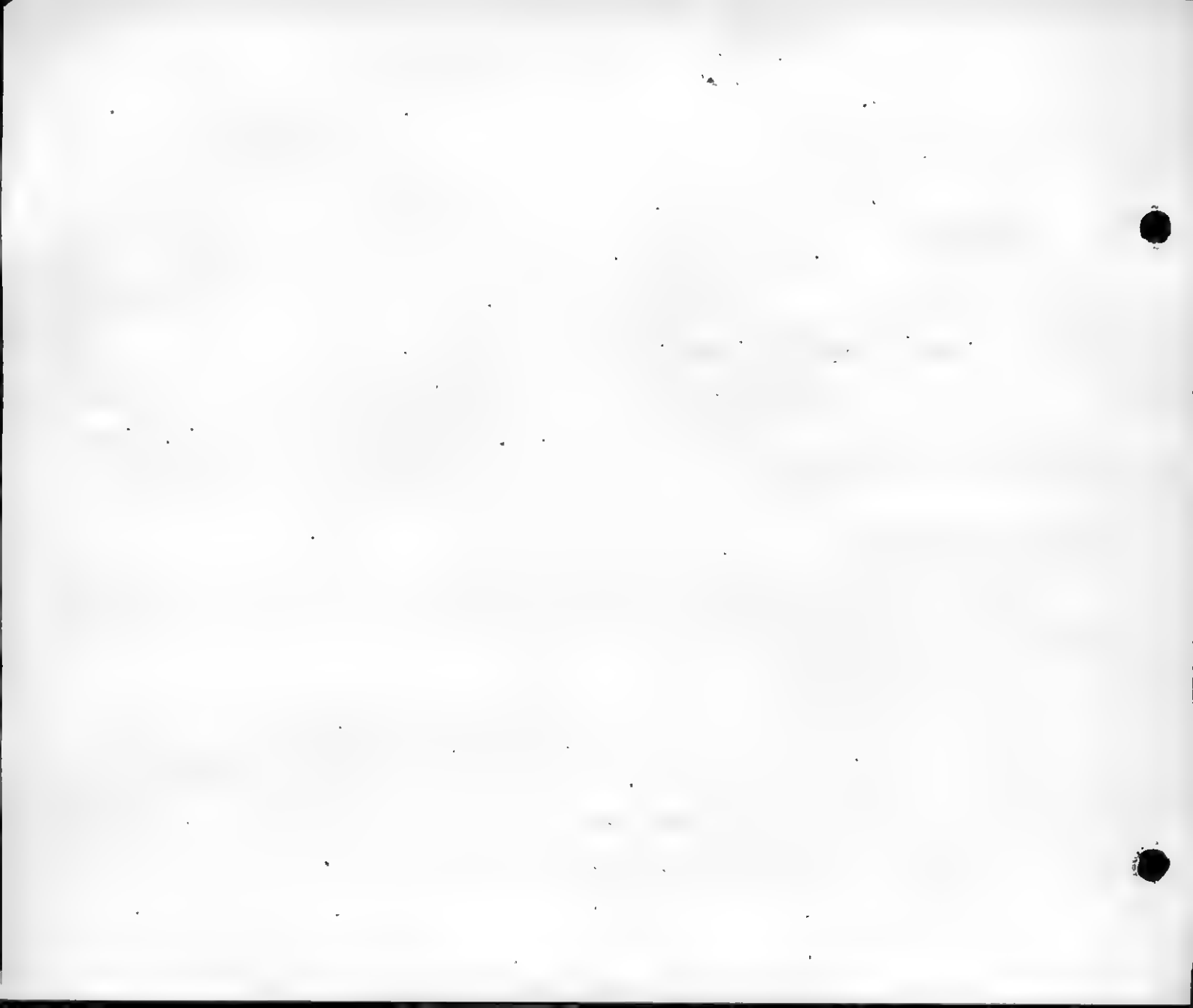
07758

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Forest Haven N.H.</b>		d. STREET ADDRESS <b>4202 Maryland Place</b>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>B.</b> Last <b>MULLER</b>		4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 25, 1887</b>
9. AGE (In years last birthday) <b>72</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Millwright - Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Engg.</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Frederick Strobel</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Wengert</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>		16. SOCIAL SECURITY NO <b>213-18-6343</b>	
INFORMANT <b>Mrs. Alfred Strobel</b>		Address <b>4202 Md. Place</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b> T42.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIO-SCLEROTIC C.V.D.</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/1</b> , 19 <b>60</b> , to <b>7/16</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>7/15</b> , 19 <b>60</b> , and that death occurred at <b>7:15</b> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5800 E. GARDEN AVE</b> DATE SIGNED <b>7/18/60</b> ACTUAL SIGNATURE <b>John H. Shaw</b> M.D. PHYSICIAN'S NAME (Type) <b>John H. Shaw M.D.</b> <b>DATE 28.11.60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-19-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Farley Funeral Home</b>		ADDRESS <b>Catonsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUL 21 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

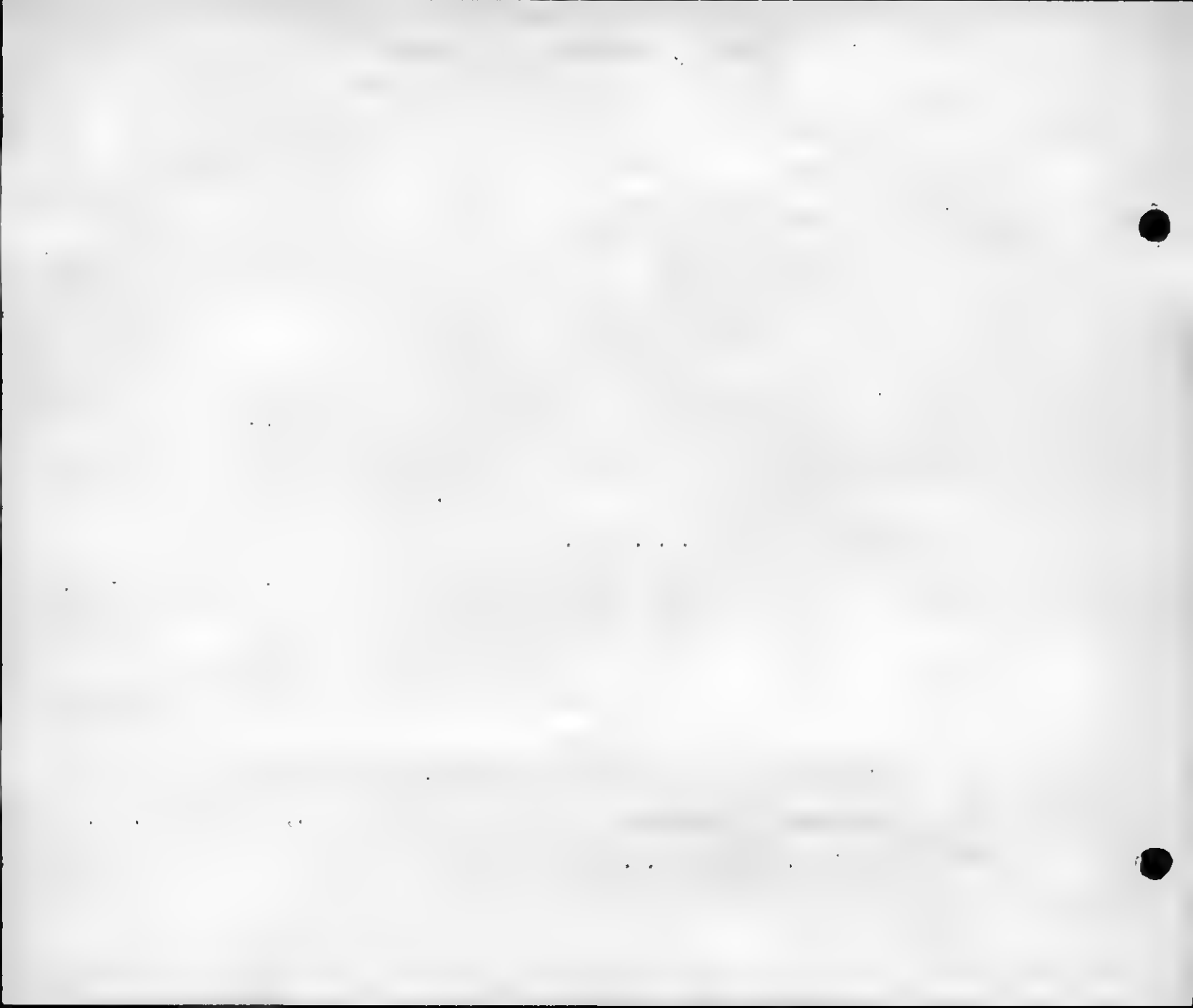
7782

## CERTIFICATE OF DEATH

07759

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm. ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Rural</u>		c. LENGTH OF STAY IN 1b <u>1 month</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Armcoast Nursing Home</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>Reid</u> Last <u>MunnikhuySEN</u>		4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20, 1876</u>
9. AGE (In years lost birthday) yrs <u>84</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William C. Reid</u>		14. MOTHER'S MAIDEN NAME <u>Cornelia Thweatt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Miss Virginia MunnikhuySEN</u>		Address <u>545 Cressy Road Bel Air, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, lower right.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>C.V.A. left.</u> DUE TO (c) <u>Hypertensive arterio-sclerotic cardio-vascular disease.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6/27/60</u> <u>4/15/60</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/15/60</u> , 19 <u>  </u> , to <u>7/3/60</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>7/1/60</u> , 19 <u>  </u> , and that death occurred at <u>12:50 P.M.</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>11 East Chase St., Baltimore-2, Md.</u>		DATE SIGNED	
ACTUAL <u>Edwin B. Jarett</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Edwin B. Jarett, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 5, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Spring Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rural Bel Air, Harford Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>		ADDRESS <u>W. Broadway &amp; Williams St. Bel Air, Maryland</u>	
24a. REC'D BY REGISTRAR <u>JUL 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kneass</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

7783

MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

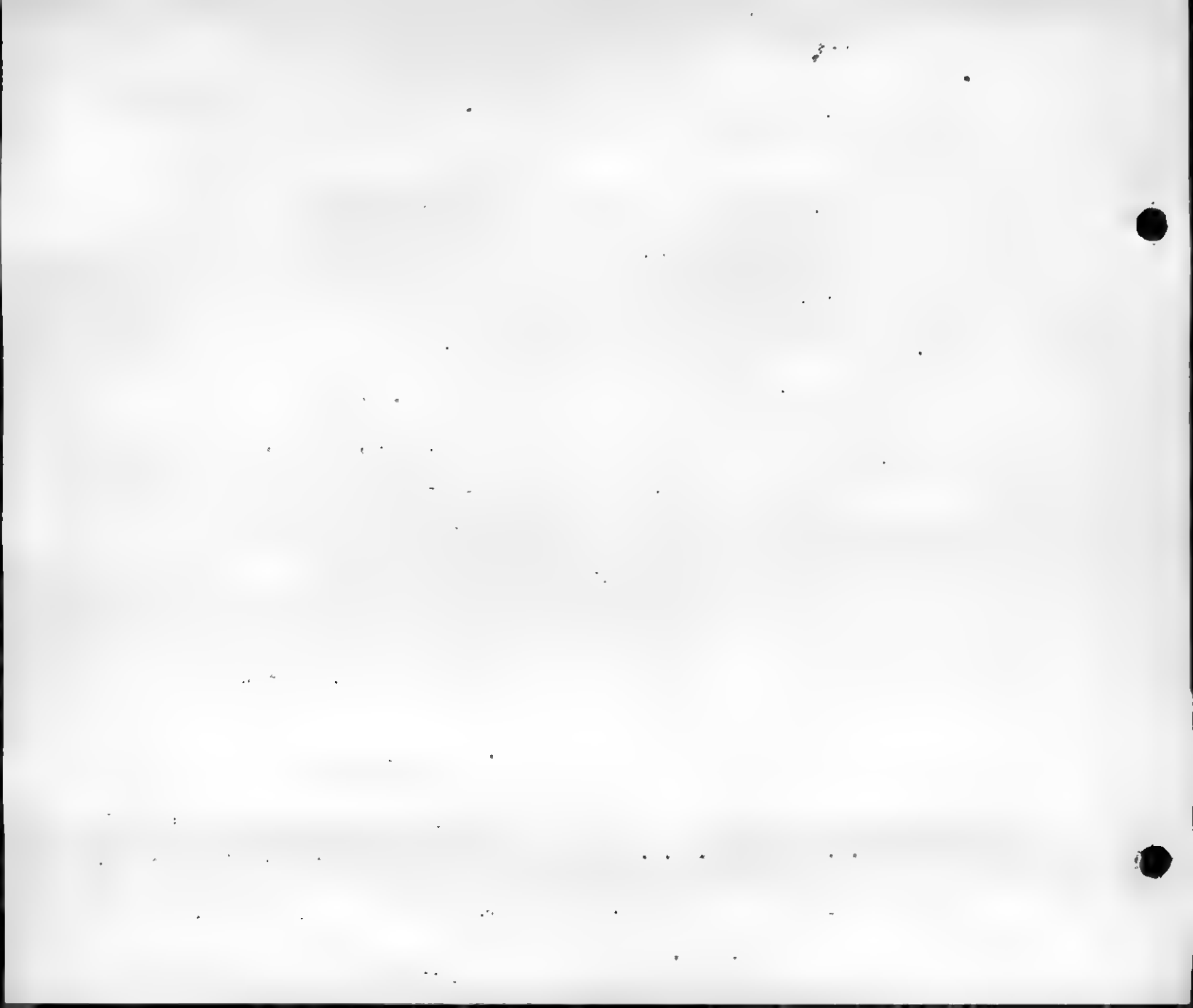
CERTIFICATE OF DEATH

07760

Item 2 filed of 1-20-60 et

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN lb <b>Towson</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Presbyterian Home</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Lancaster</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> d. STREET ADDRESS <b>c/o C. S. Wiley</b> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ella</b> Middle <b>Wiley</b> Last <b>Murphy</b>		4. DATE OF DEATH Month <b>July</b> Day <b>12</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>81</b> yrs
9. AGE (In years last birthday) <b>81</b> yrs		10. IF UNDER 1 YEAR Months <b>81</b> Days <b>12</b> Hours <b>19</b> Min <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Maryland</b>	
13. FATHER'S NAME <b>James Rankin Wiley</b>		14. MOTHER'S MAIDEN NAME <b>Alice B. Wells</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Presbyterian Home, Towson, Maryland</b>	
17. INFORMANT <b>Presbyterian Home, Towson, Maryland</b>		Address <b>Presbyterian Home, Towson, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral thrombosis - recurrent</b> DUE TO (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <b>4 wks</b> <b>3 years</b> <b>years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>(S. J. Venable, Jr.)</b> attended the deceased from <b>Jan. 19 58</b> to <b>July 12 19 60</b> that (I) <b>(S. J. Venable, Jr.)</b> saw the deceased alive on <b>July 6 1960</b> and that death occurred at <b>6:20 a.m.</b> the causes and on the date stated above.			
22a. SIGNATURE <b>S. J. Venable, Jr. M.D.</b>		22b. DATE SIGNED <b>July 13, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. J. Venable, Jr. M.D.</b>		22d. ADDRESS <b>7215 York Road, Baltimore 12, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-14-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham Presbyterian</b>		23d. LOCATION (City, town, or county) (State) <b>Rising Sun, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons, Inc. 1900 Eutaw Place</b>		25a. REC'D BY REGISTRAR <b>JUL 14 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Carlton L. Kline</b>			

MEDICAL CERTIFICATION



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

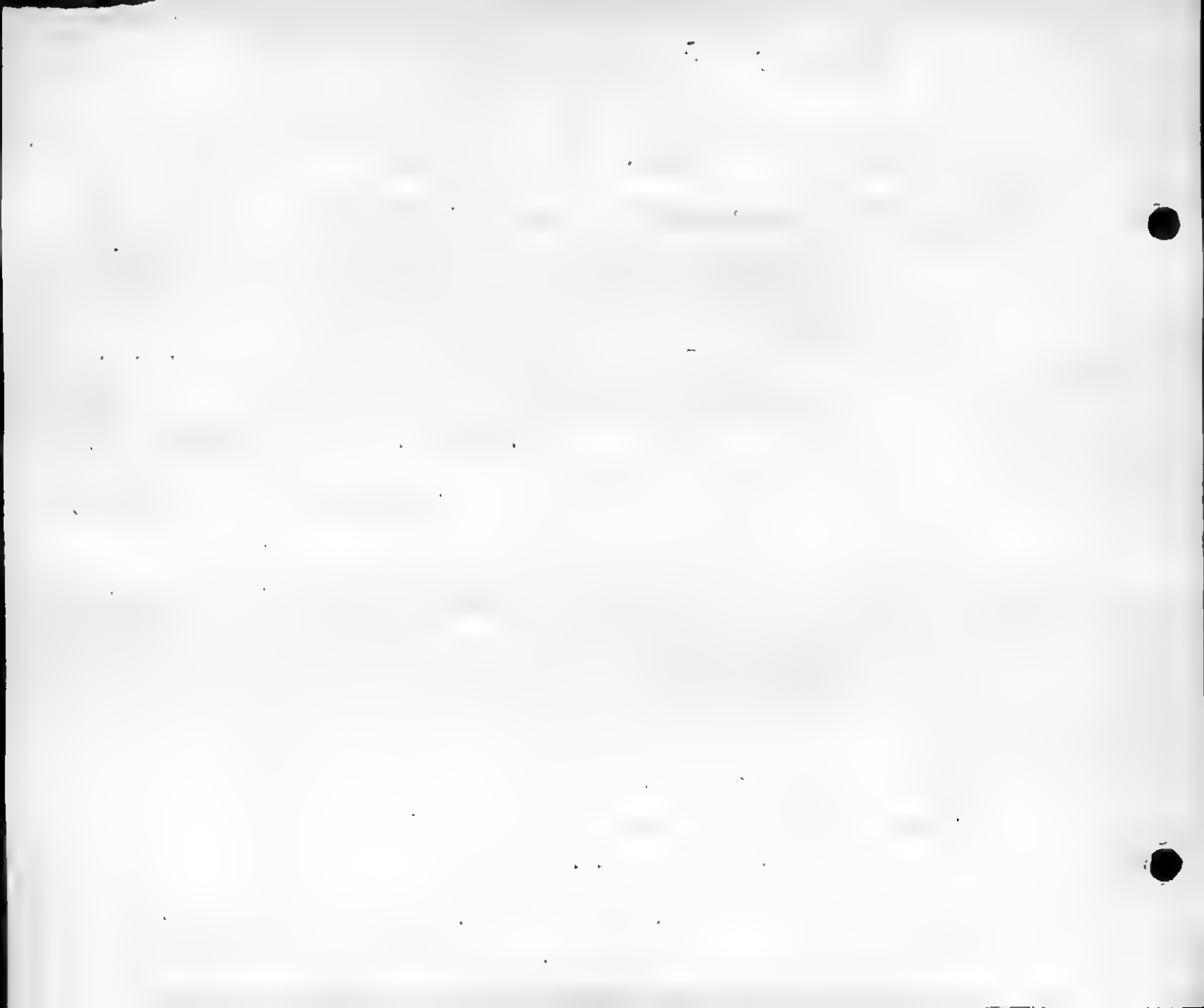


**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

7784

07761

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			c. LENGTH OF STAY IN 1b <b>2 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stella Maris Hospice, Inc.</b>				d. STREET ADDRESS <b>50 E. Main Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle Last <b>Murphy</b>				4. DATE OF DEATH Month <b>4</b> Day <b>30th</b> Year <b>1960</b>				
5 SEX <b>Female</b>		6 CO. OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/13/73</b>		
9. AGE (In years lost birthday) <b>86 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11 BIRTHPLACE (State or foreign country) <b>County Cork, Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown John Ryan</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Rev. John J. Murphy Baltimore, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>142X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Hypertensive Cardio-Renal</b> DUE TO (c) <b>Vascular Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>12 Hrs</b>  <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a m. p m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>May 18</b> to <b>July 30, 1960</b> and that death occurred on <b>July 30, 1960</b> and that death occurred at <b>18</b> from the causes and on the date stated above.								
22a. SIGNATURE <b>Charles F. O'Donnell</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell- M.D.</b>				22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>8-4-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Amesbury, Mass.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck 5305 Harford Rd.</b>				25a. REC'D BY REGISTRAR <b>DATE AUG 2 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7785

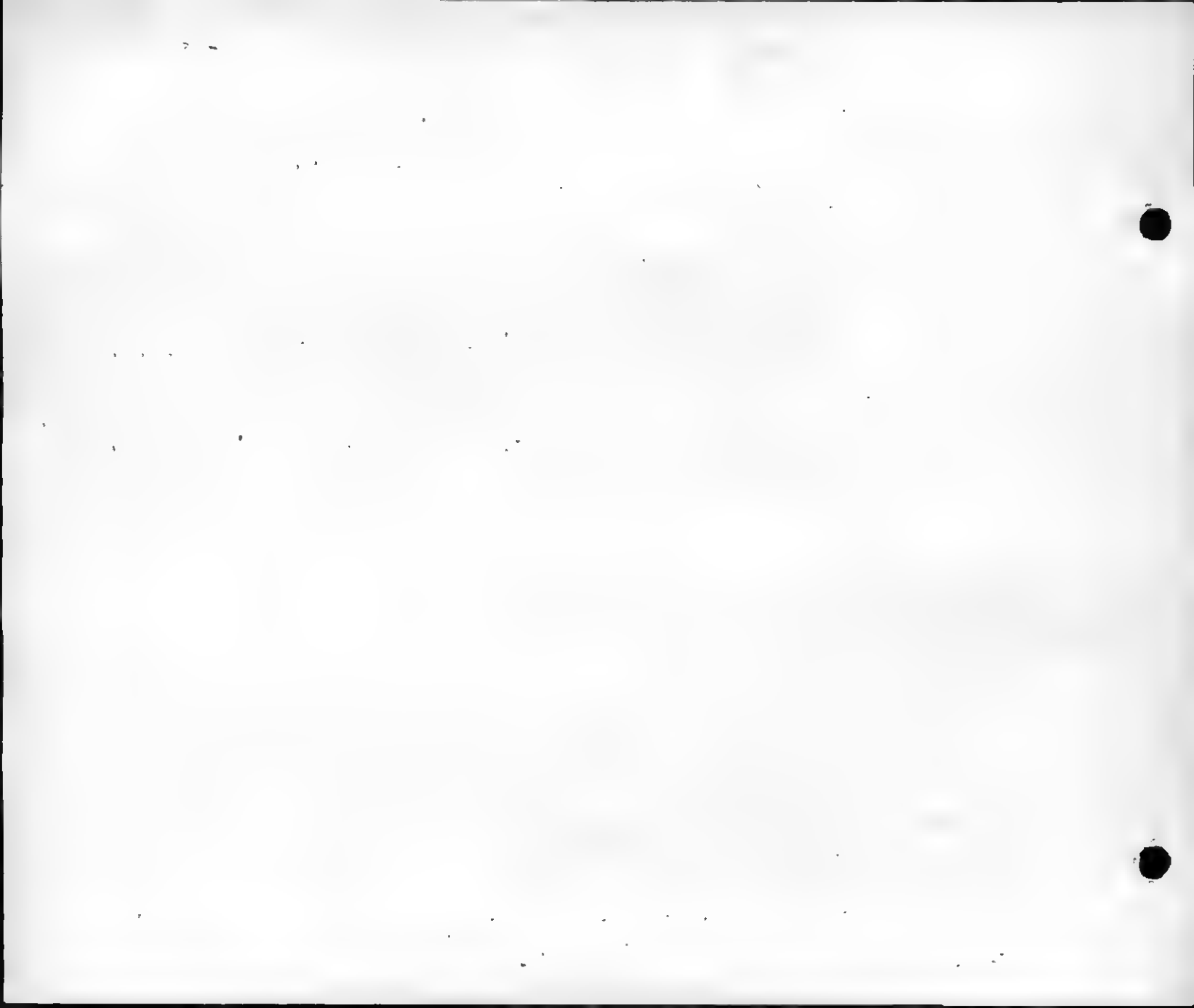
## CERTIFICATE OF DEATH

Reg. Dist. No.

07762

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm ssion) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville 8, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>618 Harrison Ave.</u>		d. STREET ADDRESS <u>618 Ralston Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Clinton</u> Middle <u>Myers</u> Last <u>Myers</u>		4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 14, 1891</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Owings Mills, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jacob Myers</u>	
14. MOTHER'S MAIDEN NAME <u>Julia Butler</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>215-30-5427</u>		17. INFORMANT <u>Mrs. Rose Myers, 618 Ralston Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Rupture of Aortic Aneurysm</u> 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>6410 Owings Mills Rd</u>	20f. (City or town) (County) (State) <u>Baltimore</u>
21. I certify that I attended the deceased from <u>3/5/60</u> , 19 <u>60</u> , to <u>7/9/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7/9/60</u> , 19 <u>60</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Milton Schleier</u>		DATE SIGNED <u>July 13 '60</u>	
PHYSICIAN'S NAME (Type) <u>Milton Schleier M.D.</u>		ADDRESS (Street, city or town, state) <u>Baltimore</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 12, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lingwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Kinnell</u>		24a. REC'D BY REGISTRAR <u>Jul 13 '60</u>	
ADDRESS <u>Frederick Co., Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move forward papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, on or within 72 hours after death.





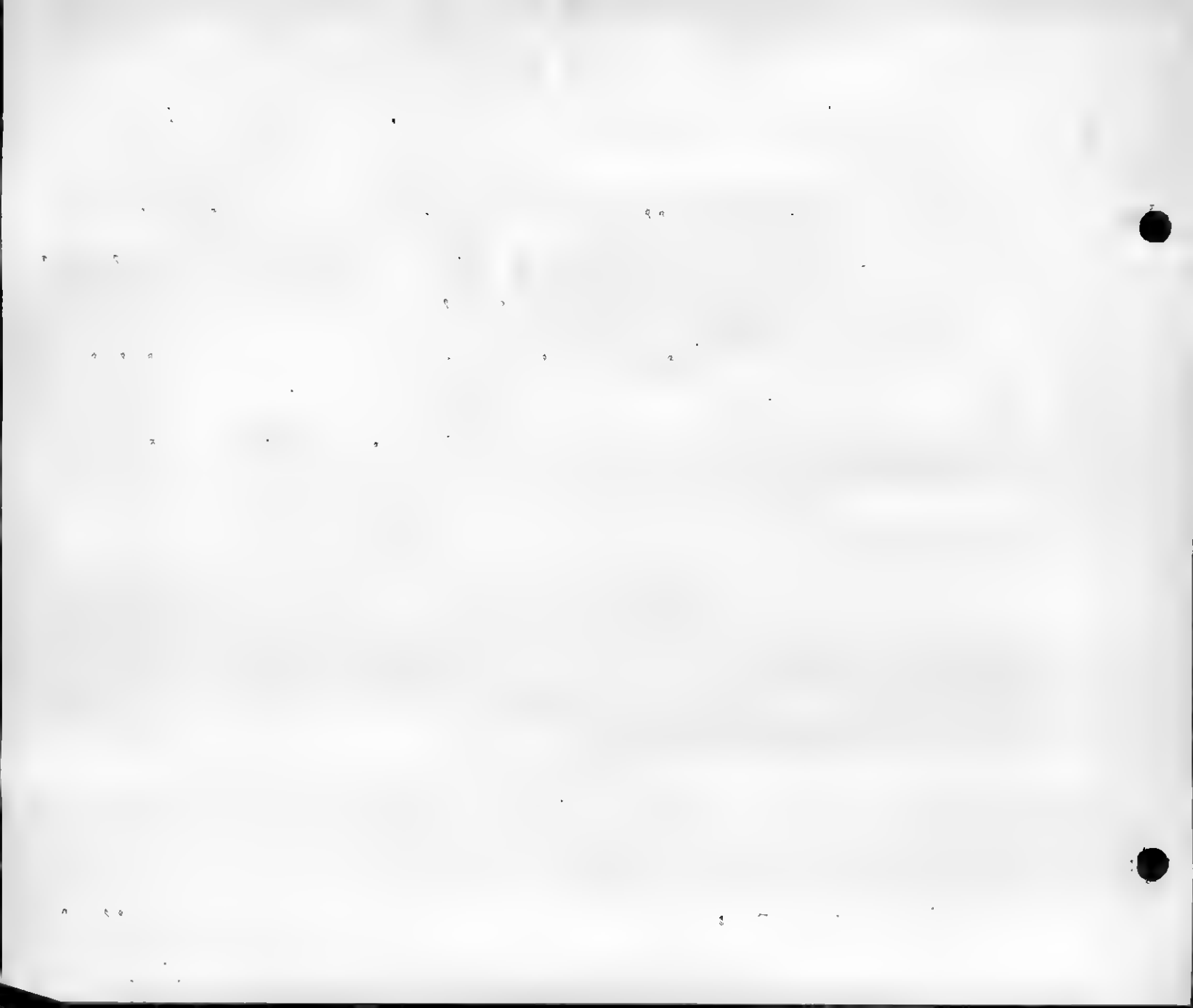


7673  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1825 Walnut Ave., # 22</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LEONARD JOSEPH NARDONE</b>		4. DATE OF DEATH Month <b>July</b> Day <b>23</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 23, 1877</b>
9. AGE (In years lost birthday) <b>83 yrs.</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Nardone</b>		14. MOTHER'S MAIDEN NAME <b>Grace Bishi</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>Antoinette A. Nardone</b>	
17. INFORMANT <b>Antoinette A. Nardone</b>		Address <b>Same.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of Esophagus</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <input type="checkbox"/> a. m. <input type="checkbox"/> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>23 July, 1960</b> , to <b>24 July, 1960</b> , that I last saw the deceased alive on <b>24 July, 1960</b> , and that death occurred at <b>2:25 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W.H. Morrison</b> M.D.		ADDRESS (Street, city or town, state) <b>3 Kiri Street, Dundalk, Md.</b>	
PHYSICIAN'S NAME (Type) <b>W.H. Morrison</b>		DATE SIGNED <b>23 July</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-26-60.</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>7401 German Hill Rd., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Geier</b>		ADDRESS <b>901 S. CONKLING ST. BALTO., MD.</b>	
24a. REC'D BY REGISTRAR <b>Jul 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



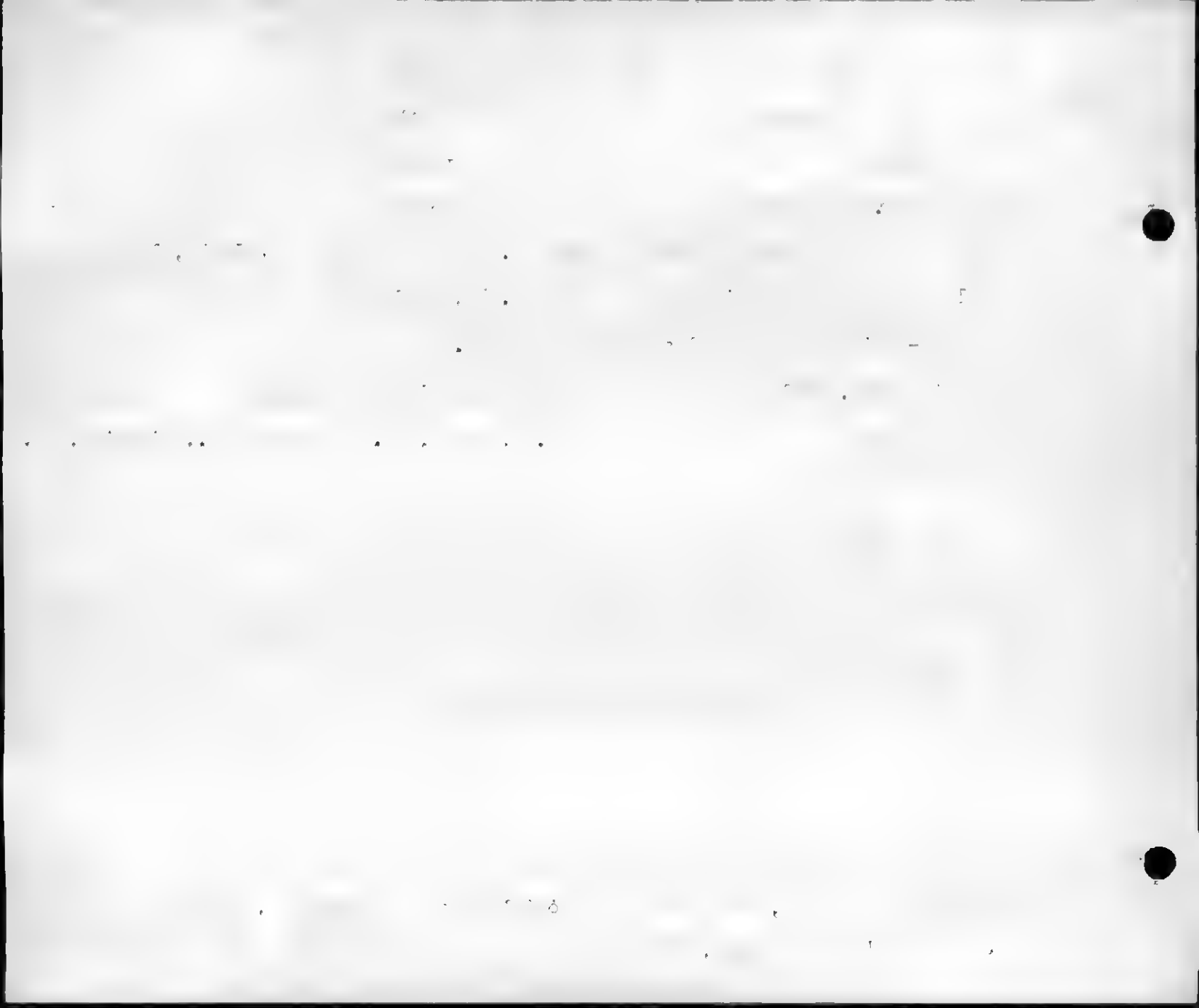
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

07765

7787

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Convalescent Home</b>				d. STREET ADDRESS <b>Chebby Chase</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM FREDERICK NEALE, SR.</b>				4. DATE OF DEATH Month Day Year <b>July 10, 1960 19</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>Widowed</b> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 10, 1883</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman-retired</b>		11. BIRTHPLACE (State or foreign country) <b>Conn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William F. Neale</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Hedges</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Wm. F. Neale, Jr. Potterspring Rd., Timonium, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-sclerotic Heart Disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Old Cerebral vascular accident</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1959</b> to <b>7/10 1960</b> , that (I) (we) last saw the deceased alive on <b>7/11 1960</b> , and that death occurred at <b>P. M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Samuel Stern M.D.</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>SAMUEL STERN</b>	
22d. ADDRESS <b>1010 E. Belvedere Av.</b>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 13, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Parkville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>				25a. REC'D BY REGISTRAR <b>JUL 13 1960</b>		25b. REGISTRAR'S SIGNATURE <b>Carroll S. Thomas</b>	

TO HOSE: ATTEND: PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO HOST OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

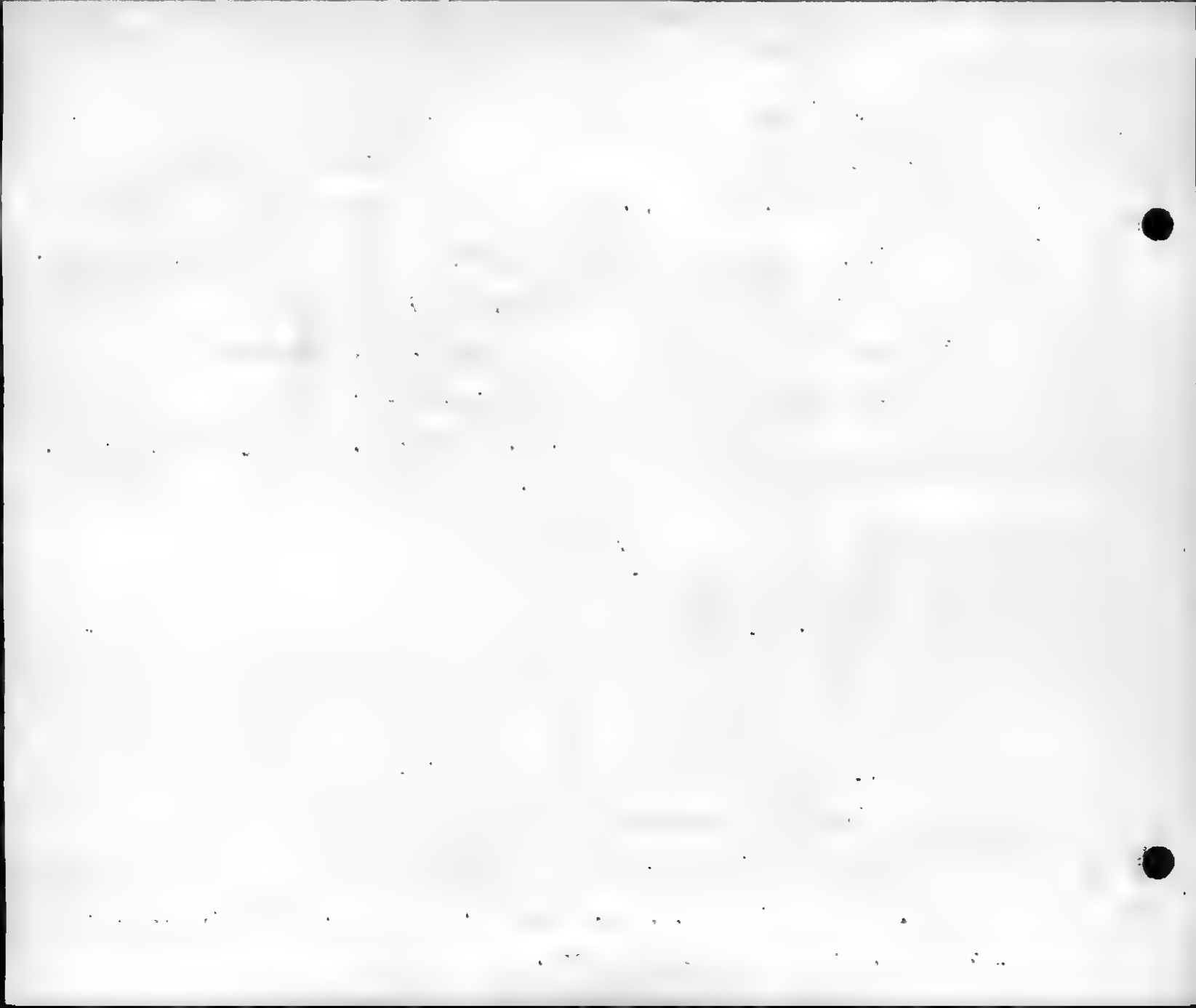
7788

## CERTIFICATE OF DEATH

07766

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Randallstown</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Chapel Hill Con. Home</i>				e. STREET ADDRESS <i>1613 Orlando Road</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs. Margaret Anna Neumann</i>				4. DATE OF DEATH Month Day Year <i>July 16th 1960</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>Cauc.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 18, 1883</i>	9. AGE (In years last birthday) yrs. <i>76</i>	10. IF UNDER 1 YEAR: Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Cumberland, Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Charles Laibel</i>				14. MOTHER'S MAIDEN NAME <i>Lena Schmidt</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.			
				INFORMANT Address <i>Mrs. Rosalia T. Good 1613 Orlando Rd.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lobar pneumonia</i> <i>122-1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hepatic failure</i> DUE TO (c) <i>ASCVD.</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Possible carcinoma of liver</i>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>June 9</i> , 19 <i>60</i> , to <i>July 16</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>June 14</i> , 19 <i>60</i> , and that death occurred at <i>9:30</i> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>John J. Darrell</i> M.D.							
PHYSICIAN'S NAME (Type) <i>JOHN J. DARRELL, M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/1 19/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Peter and Paul</i>		22d. LOCATION (City, town, or county) (State) <i>Cumberland, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Road.</i>				24a. REC'D BY REGISTRAR DATE <i>JUL 18 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	



1  
FOR STATE  
HEALTH DEPT.

TO CLERK MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
7789 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07767

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b>			
c. LENGTH OF STAY IN TB				d. STREET ADDRESS <b>6807 Bellona Avenue</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6807 Bellona Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MABEL</b>		First Middle Last <b>G. NICHOLS</b>		4. DATE OF DEATH <b>July 26 1960</b>		5. SEX <b>Female</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 2, 1893</b>		9. AGE (In years less birthday) <b>66</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(ret'd) secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rupert Terminals Corporation</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James.. Nichols</b>				14. MOTHER'S MAIDEN NAME <b>Gertrude Rothrock</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT <b>213-01-1562 Warren E. Nichols, 1226 St. Paul Street</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Partial</b> 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Petty</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 22b. DATE THEREOF <b>7-28-60</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b> 22d. LOCATION (City, town, or country) (State) <b>Baltimore</b> 23. FUNERAL DIRECTOR ADDRESS <b>William Cook, Inc., 1217 St. Paul Street</b> 24a. REC'D BY REGISTRAR <b>JUL 29 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>							

DATE SIGNED  
7/26/60

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07768

7674

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>PENNA.</u> b. COUNTY <u>ALLEGANY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN 1b <u>3 mos 23 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BROOKING HWY - NR. DUNDALK AVE</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spring, Tennessee</u>	
f. STREET ADDRESS <u>528 N. 2nd St</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>THOMAS TACENEC Noecker</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>4</u> Year <u>19 60</u>	
5. SEX <u>M. M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>Nov. 26, 1928</u>	9. AGE (In years last birthday) <u>31</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>"None"</u>	
11. BIRTHPLACE (State or foreign country) <u>Earl Township, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Heather</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>204-22-2963</u>	
17. INFORMANT <u>James Noecker Jr 76 Dundalk Rd</u>		Address <u>Dundalk, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound Fracture of Skull</u>			
Conditions, if any, which gave rise to immediate cause (b) <u>Crushed Chest</u>			
(c) <u>None</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>RAN Auto onto Bridge + turned over</u>	
20c. TIME OF INJURY Month, Day, Year <u>7-4-60</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) <u>Bridge</u>	20f. (City or town) <u>DUNDALK - BALTO MD</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. CHIEF, MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. DAVIS MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/7/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		22d. LOCATION (City, town, or county) <u>Spring, Tennessee</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. J. W. ...</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Thomas</u>	
ADDRESS <u>6306 Belair Rd, Baltimore - 6, Md</u>		DATE <u>AUG 2 '60</u>	

DATE SIGNED

7/7/60



may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

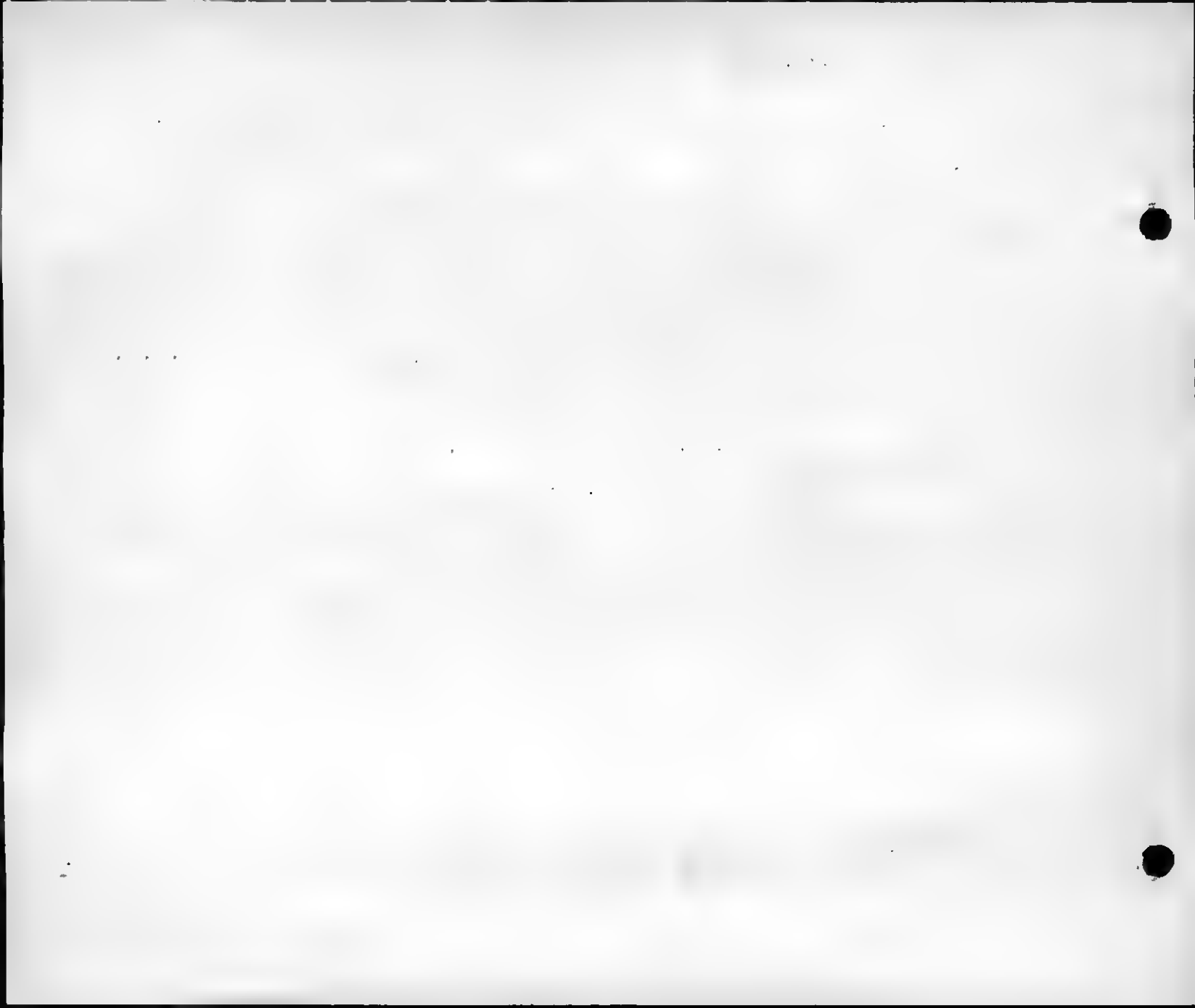
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7790

## CERTIFICATE OF DEATH

07769

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Rural Randallstown</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Randallstown</u>				d. STREET ADDRESS <u>Marriottsville Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Marriottsville Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>Annie Lee Odell</u>				4. DATE OF DEATH <u>July 20 1960</u>			
5 SEX <u>Female</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>July 28, 1875</u>	
9 AGE (In years last birthday) <u>84</u> yrs		IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min</u>		IF UNDER 24 HRS <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min</u>			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Henry Ehlers</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Holbrook</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16 SOCIAL SECURITY NO <u>218-32-1973</u>		17 INFORMANT <u>Ruth O. Enos</u> Address <u>Randallstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of uterus</u> 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiovascular disease</u> INTERVAL BETWEEN ONSET AND DEATH							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>7/20/1960</u> that (I) (we) last saw the deceased alive on <u>7/20/1960</u> and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
22a SIGNATURE <u>Annie E. Martin</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c PHYSICIAN'S NAME (Type) <u>Wm. F. Martin</u>				22d ADDRESS <u>RAZDALLSTOWN</u> <u>MD</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>7/22/60</u>		23c NAME OF CEMETERY OR CREMATORY <u>Mount Paran Cemetery</u>		23d LOCATION (City, town, or county) (State) <u>Randallstown, Maryland</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Luther R. Knight</u>				25a REC'D BY REGISTRAR <u>DATE JUL 25 '60</u>		25b REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

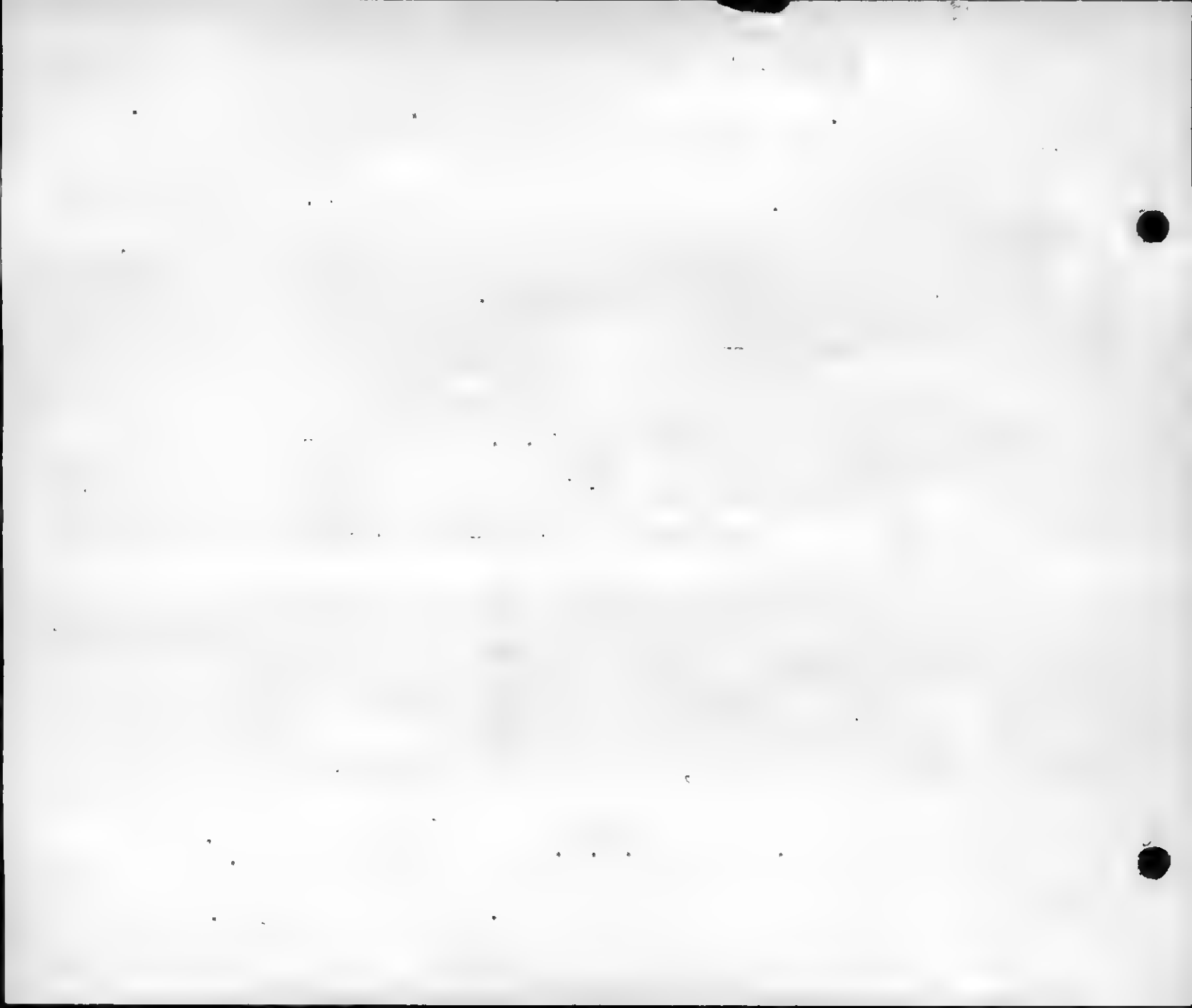


VR A1S (4)  
ISM 9/59

## 7791

07770

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2702 Gwynnmore Ave.</b>				d. STREET ADDRESS <b>2702 Gwynnmore Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Glenna Davis Paxton</b>				4. DATE OF DEATH Month Day Year <b>July 12, 1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 17, 1876</b>		9. AGE (In years last birthday) yrs. <b>83</b>	IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Henry Davis</b>				14. MOTHER'S MAIDEN NAME <b>Mary Minor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. R. Irving Paxton - 4038 The Alameda</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>422.1</b> DUE TO Conditions "if any, which gave rise to immediate cause (a), stating the underlying cause lost." (b) <b>Arteriosclerotic cardio-vascular disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>10 years</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18) <b>*****</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>****</b> 19 p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>****</b>		20f. (City or town) (County) (State) <b>*****</b>	
21. I certify that (I) (his hospital) attended the deceased from <b>February 1960</b> to <b>7/11 1960</b> , that (I) (we) last saw the deceased alive on <b>July 11, 1960</b> , and that death occurred at <b>6:30 A.M.</b> the causes and on the date stated above.							
22a. SIGNATURE <i>Millard T. Traband, Jr.</i>				M. D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>7/13/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Millard T. Traband, Jr. M. D.</b>				22d. ADDRESS <b>5101 Gwynn Oak Ave. Baltimore, 7, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/14/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>		23d. LOCATION (City, town, or county) (State) <b>Elkridge, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. G. Sickener &amp; Sons - Balt., Md.</i>				ADDRESS <b>Baltimore, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 13 '60</b>	
				25b. REGISTRAR'S SIGNATURE <i>Richard S. Thomas</i>			



# 1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7792

## CERTIFICATE OF DEATH

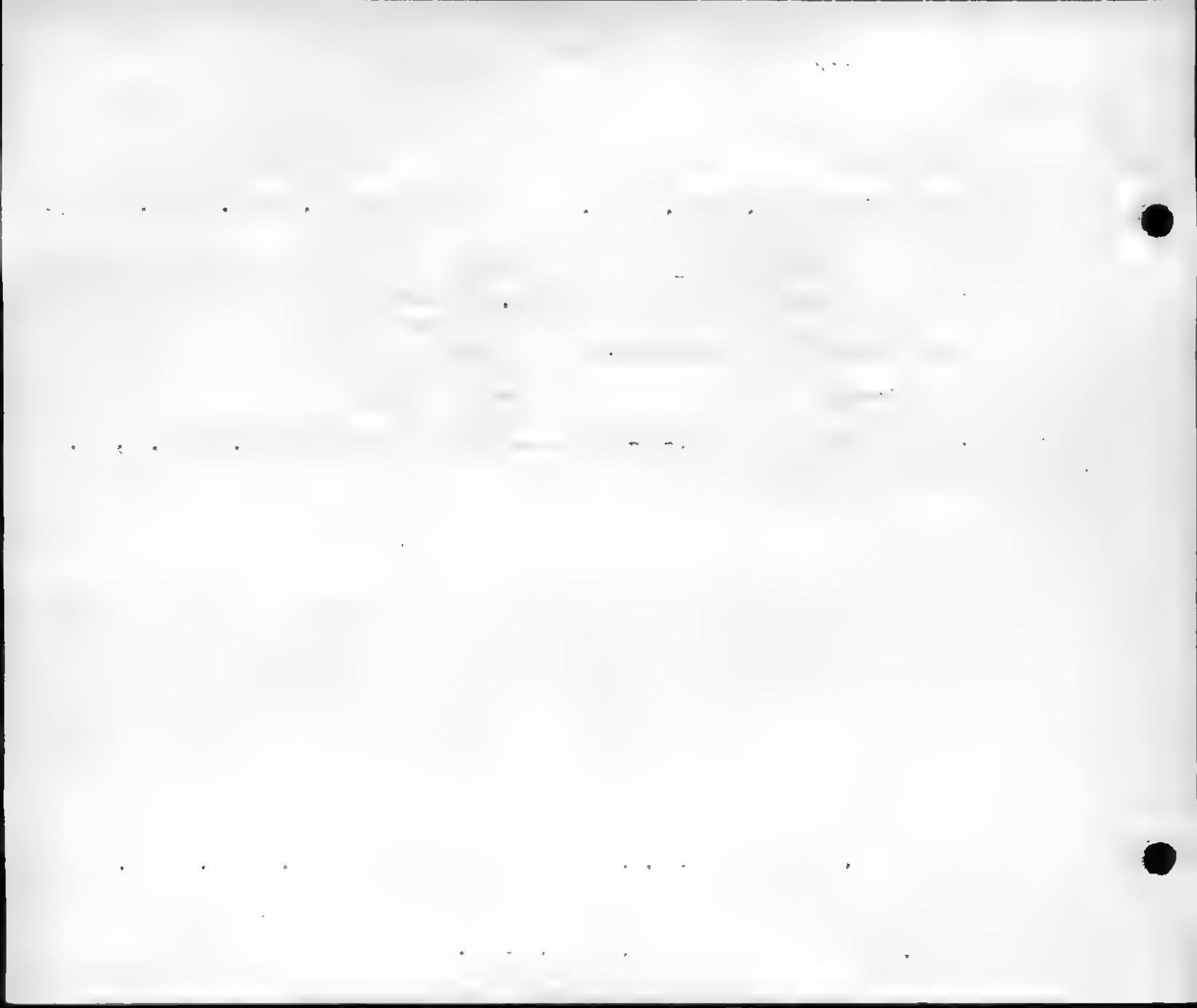
07771

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL ROSEDALE</b>		c. LENGTH OF STAY IN 1b <b>6 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7614 Wilhelm Ave. Balto. 6, Md.</b>		e. STREET ADDRESS <b>7614 Wilhelm Ave. Balto. 6, Md.</b>	
3 NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>PENTA</b> Last <b>PENTA</b>		4. DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>1960</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Dec. 13, 1894</b>
9 AGE (in years last birthday) <b>65</b> yrs		IF UNDER 1 YEAR Months <b>5</b> Days <b>19</b> Hours <b>60</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Superintendent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	11 BIRTHPLACE (State or foreign country) <b>Italy</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13 FATHER'S NAME <b>Michael</b>	
14. MOTHER'S MAIDEN NAME <b>Lucia</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>WW I</b>	
16. SOCIAL SECURITY NO. <b>215-05-6237</b>		17. INFORMANT <b>John Penta 7614 Wilhelm Ave. Balto. 6, Md.</b>	
18 CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Polycythemia vera</b> DUE TO (c) <b>?</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>5 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 1959</b> to <b>July 1960</b> that I last saw the deceased alive on <b>7/3/1960</b> , and that death occurred at <b>1:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8019 Philadelphia Rd. Balto. 6</b> DATE SIGNED <b>7/3/60</b> ACTUAL SIGNATURE <b>A. Clark Holmes, M.D.</b> M.D. <b>8019 Philadelphia Rd. Balto. 6, Md. 7/3/60</b> PHYSICIAN'S NAME (Type) <b>A. Clark Holmes, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 7, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23 FUNERAL DIRECTOR'S SIGNATURE <b>Philip E. Cvach 1211 Chesaco Ave. Balto. 6, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 7 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Rouse</b>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

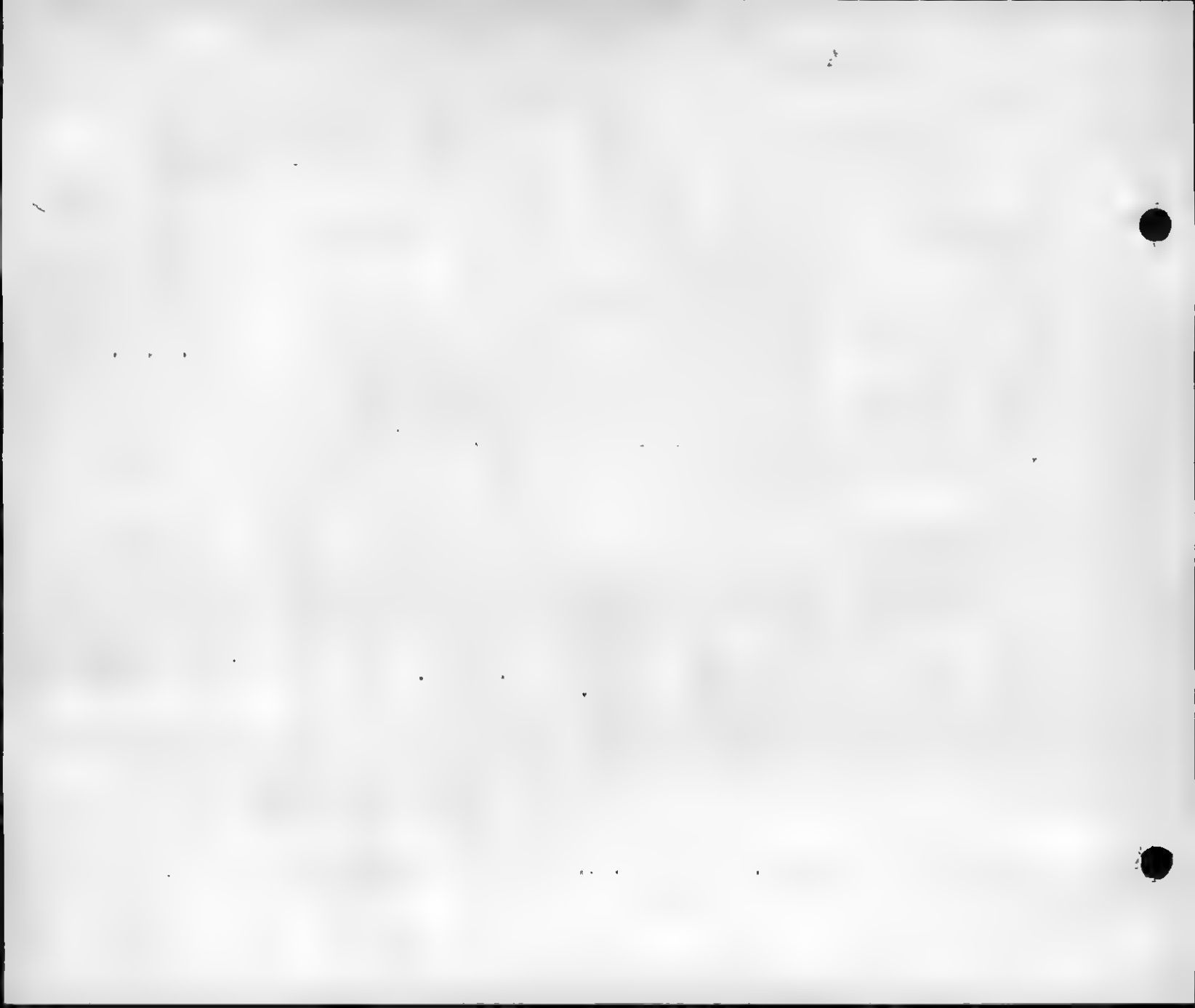
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DE: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the above is necessary, please execute a separate certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)  
SM 5/55

17-2-18-60 <b>MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18</b>									
<b>7793 MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>									
Reg. Dist. No. <b>07772</b>									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN TB <b>2mth5dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore County - Catonsville</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>					d. STREET ADDRESS <b>11 Wade Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Oscar</b> Middle <b>H</b> Last <b>Pulliam</b>					4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>1960</b>				
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 18, 1887</b>		9. AGE (In years last birthday) <b>73</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>					14. MOTHER'S MAIDEN NAME <b>Lucietta Gerring</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>					16. SOCIAL SECURITY NO. <b>219-10-6854</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>904.7</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Broncho <del>Pneumonia</del> Pneumonia</b> (c) <b>Fracture of right hip (femur) Accident</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Pt. was found with intertrochanteric frac. of rt. femur - do not know the exact reason for this.</b>				
20c. TIME OF INJURY Hour <b>12:15</b> <b>PM</b> Day <b>5-26</b> Year <b>1960</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>hospital</b>		20f. (City or town) <b>Catonsville 28, Maryland</b>		(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>George M. Kieffer, M. D.</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>					DATE SIGNED <b>July 8, 60</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>7/11/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Torrain</b>			22d. LOCATION (City, town, or county) (State) <b>Baltimore Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James D. Smith &amp; Son Co.</b>					24a. REC'D BY REGISTRAR <b>JUL 11 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Hines</b>		



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7794

07773

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7402 Knollwood Road</b>				d. STREET ADDRESS <b>7402 KNOLLWOOD RD (24)</b>			
3. NAME OF DECEASED (Type or print) <b>WASHINGTON ROBY PURNELL</b>				4. DATE OF DEATH <b>JULY 24 1960</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 12, 1902</b>		9. AGE (In years last birthday) <b>57</b>	10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ART DEALER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Purnell Art Galleries</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO. MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>WASHINGTON ROBY PURNELL, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>NORA BORTH</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>219-32-6779</b>		17. INFORMANT <b>MRS PURNELL</b>		Address <b>JAME</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGES</b>							<b>2-3 YRS</b>
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <b>HYPERTENSION</b>							<b>20-30 YRS</b>
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/20 1960</b> to <b>7/24 1960</b> , that (I) (we) last saw the deceased alive on <b>7/24 1960</b> and that death occurred at <b>5 AM</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>George J. Burke</b>				22b. DATE SIGNED <b>7/24/60</b>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <b>301 E UNIVERSITY PKY</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/27/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Pikesville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. T. [Signature]</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 26 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. [Signature]</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



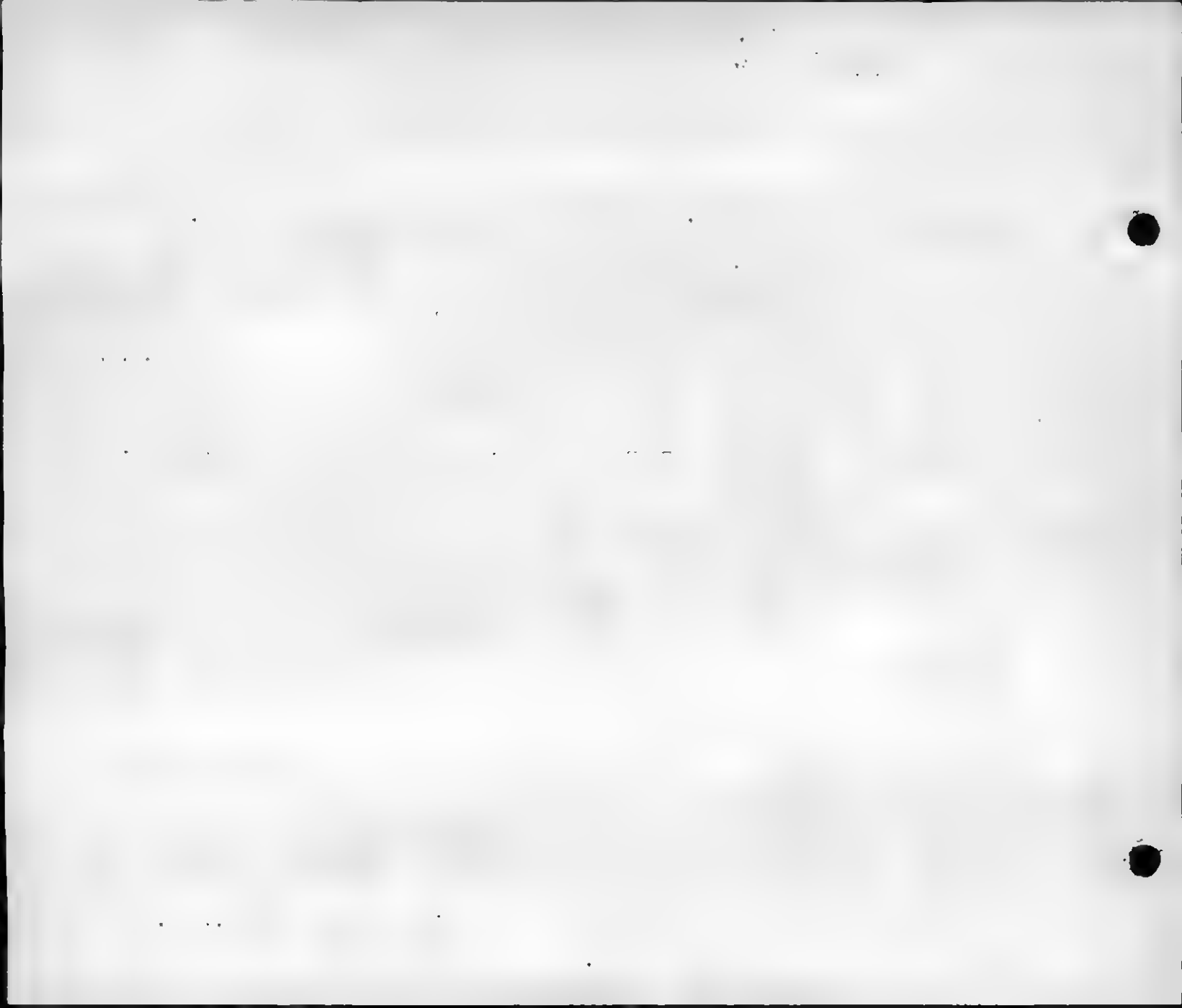
## 7795 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut an Residence before admision) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex (21)</u>		c. LENGTH OF STAY IN 1b <u>24</u> <u>Essex (21)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1604 Rickenbacker Rd.</u>		d. STREET ADDRESS <u>1604 Rickenbacker Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>ESTELLA C. (HARTMAN) QUILLIN</u>		4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>March 7, 1896</u>
9. AGE (in years last birthday) <u>64</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Hennan</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>212-03-0805D</u>	
17. INFORMANT <u>Andrew Hartman</u>		Address <u>1804 Middleborough Rd. #21</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-C-V-DISEASE</u>			
DUE TO <u>DIABETES MELLITUS</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u>		DATE SIGNED <u>7/8/60</u>	
EXAMINER'S NAME (Type) <u>M.B. DAVIS MD</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/9/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Jesus</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Pruzdzinski</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 12 '60</u>	
ADDRESS <u>1407 Eastern Ave.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7796

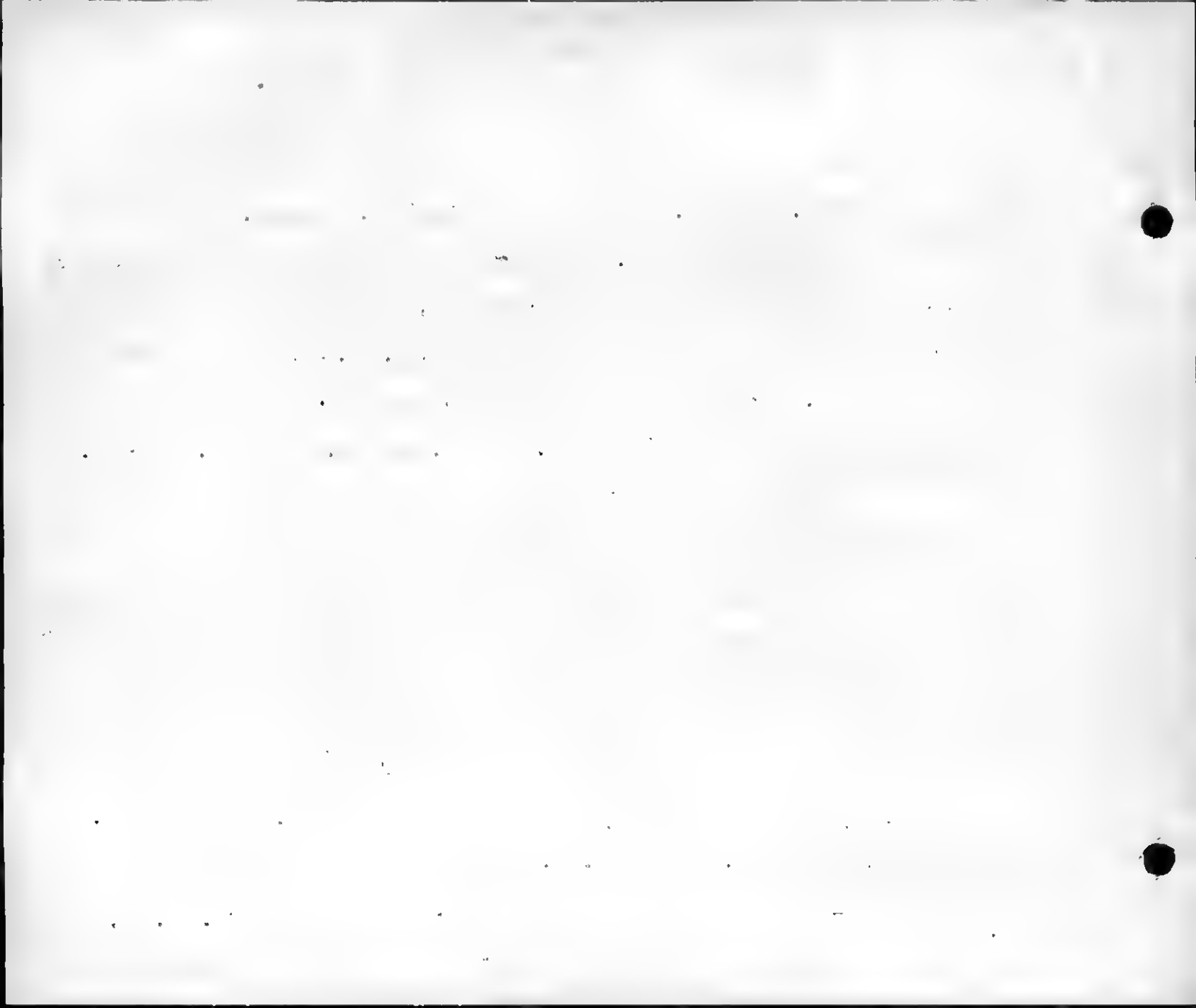
## CERTIFICATE OF DEATH

Reg. Dist. No.

07775

<b>1 PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 21 E. Joppa Rd.</u>				<b>2 USUAL RESIDENCE</b> (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Baltimore</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u> d. STREET ADDRESS <u>Box 21 E. Joppa Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3 NAME OF DECEASED</b> (Type or print) <u>Nellie</u> <u>G.</u> <u>Reed</u> 5 SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 26, 1884</u> 9. AGE (In years last birthday) <u>76</u> yrs.				4. DATE OF DEATH <u>July 12, 1960</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> 11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Walter C. Gambrill</u> 14. MOTHER'S MAIDEN NAME <u>Imogene Owens</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO <u>None</u> INFORMANT <u>Mr. David H. Reed Sr.</u> Address <u>Box 21 E. Joppa Rd.</u>				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO (b) <u>coronary thrombosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetis mellitus</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <u>January 18, 1958</u> to <u>July 12, 1960</u> that I last saw the deceased alive on <u>July 12, 1960</u> and that death occurred at <u>8:50 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9660 Belair Rd. Balto 6, Md.</u> DATE SIGNED <u>7/13/60</u> ACTUAL SIGNATURE <u>Theodore E. Evans, M.D.</u> PHYSICIAN'S NAME (Type) <u>Theodore E. Evans, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>7-16-1960</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Camp Chapel Methodist</u> 22d. LOCATION (City, town, or county) (State) <u>Joppa Rd. Balto. Co. Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Lasswell Funeral Home</u> ADDRESS <u>7401 Belair Rd.</u> 24a. REC'D BY REGISTRAR DATE <u>JUL 14 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Charles S. Evans</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

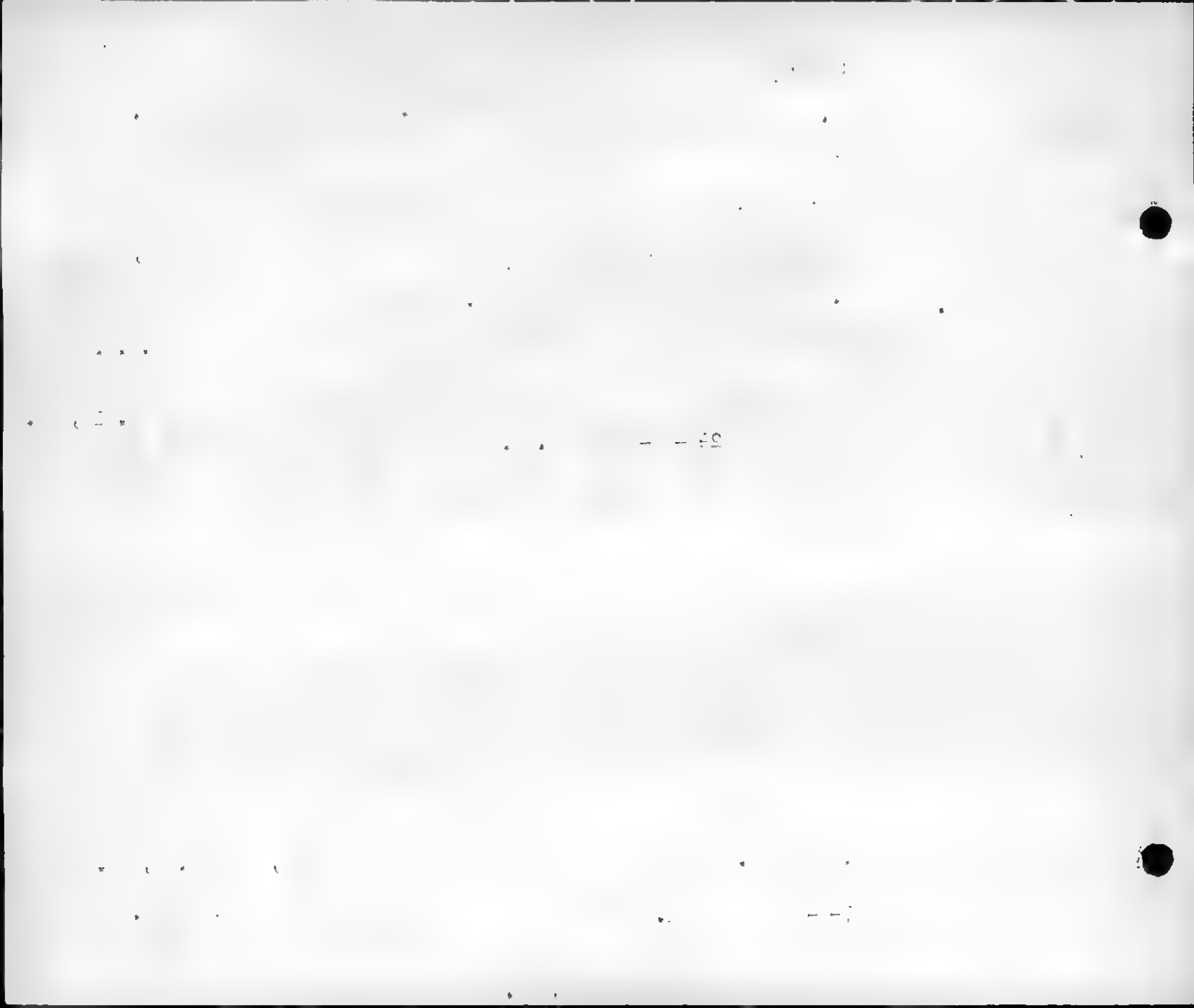


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3 after death. Page 2 of 3 after death. Page 3 of 3 after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

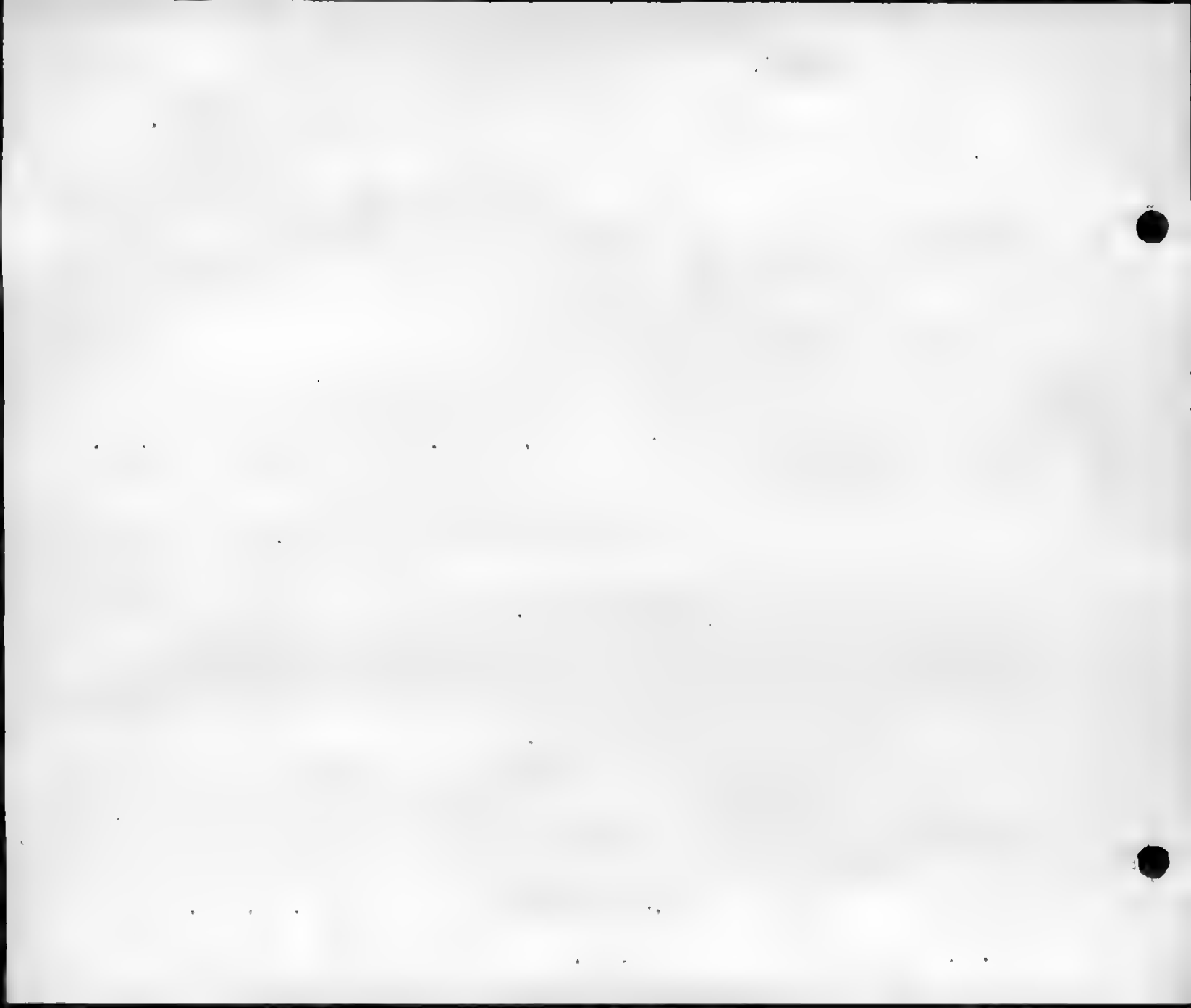
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
7797  
CERTIFICATE OF DEATH

077776

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebbville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebbville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3216 Rolling Road</b>				e. STREET ADDRESS <b>3216 Rolling Road</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF <b>George</b> First <b>Winfield</b> Middle <b>Reiblich</b> Last				4. DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>M.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 9, 1880</b>	
9. AGE (In years lost birthday) <b>79</b> yrs		10. F UNDER 1 YEAR		11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>George Reiblich</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Schmidt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>***** 318-38-3692</b>		17. INFORMANT <b>Mr. G. Kenneth Reiblich 6311 Boxwood Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Excrescence of stomach with metastases</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>one year</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <b>one year</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 10, 1955</b> to <b>7/3, 1960</b> that (I) (we) last saw the deceased alive on <b>7/3, 1960</b> and that death occurred at <b>1:25 PM</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>Edwin L. Pierpont</b>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>7/5/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Edwin L. Pierpont</b>				22d. ADDRESS <b>8204 Liberty Road, Balto. 7, Md.</b>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-6-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Randallstown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Living Rogers</b>				ADDRESS <b>8728 Liberty Road</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 7 '60</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	







may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These release remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7799

07778

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>7yr6mth5dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Clermont</b> Last <b>Rivers</b>				4. DATE OF DEATH Month <b>July</b> Day <b>19</b> Year <b>1960</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 15, 1877</b>	9. AGE (In years last birthday) <b>82</b> yrs	IF UNDER 1 YEAR Months <b>19</b> Days <b>19</b> Hours <b>60</b> Min.		
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>woodwork</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Knock Co.</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Aurestus H. Rivers</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Stevenson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>213-09-9858</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis with effusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>old Cerebral vascular accident - Generalized arteriosclerosis</b> DUE TO (c) <b>old Cerebral vascular accident - Generalized arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>old Cerebral vascular accident - Generalized arteriosclerosis</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <b>July</b> Day <b>12</b> Year <b>1960</b> Hour <b>a. m.</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 12, 1960</b> to <b>July 19, 1960</b> , that (I) (we) last saw the deceased alive on <b>July 19, 1960</b> , and that death occurred at <b>7:45</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Stella Wachslar, M. D.</b>				22b. DATE SIGNED <b>7-19-60</b>		22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>	
22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>	
23a. BURIAL CREMATION <b>Burial</b>		23b. DATE THEREOF <b>7/22/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>4300 Old Joe Louck Rd.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Brownson</b>				25a. REC'D BY REGISTRAR <b>HUL 20 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

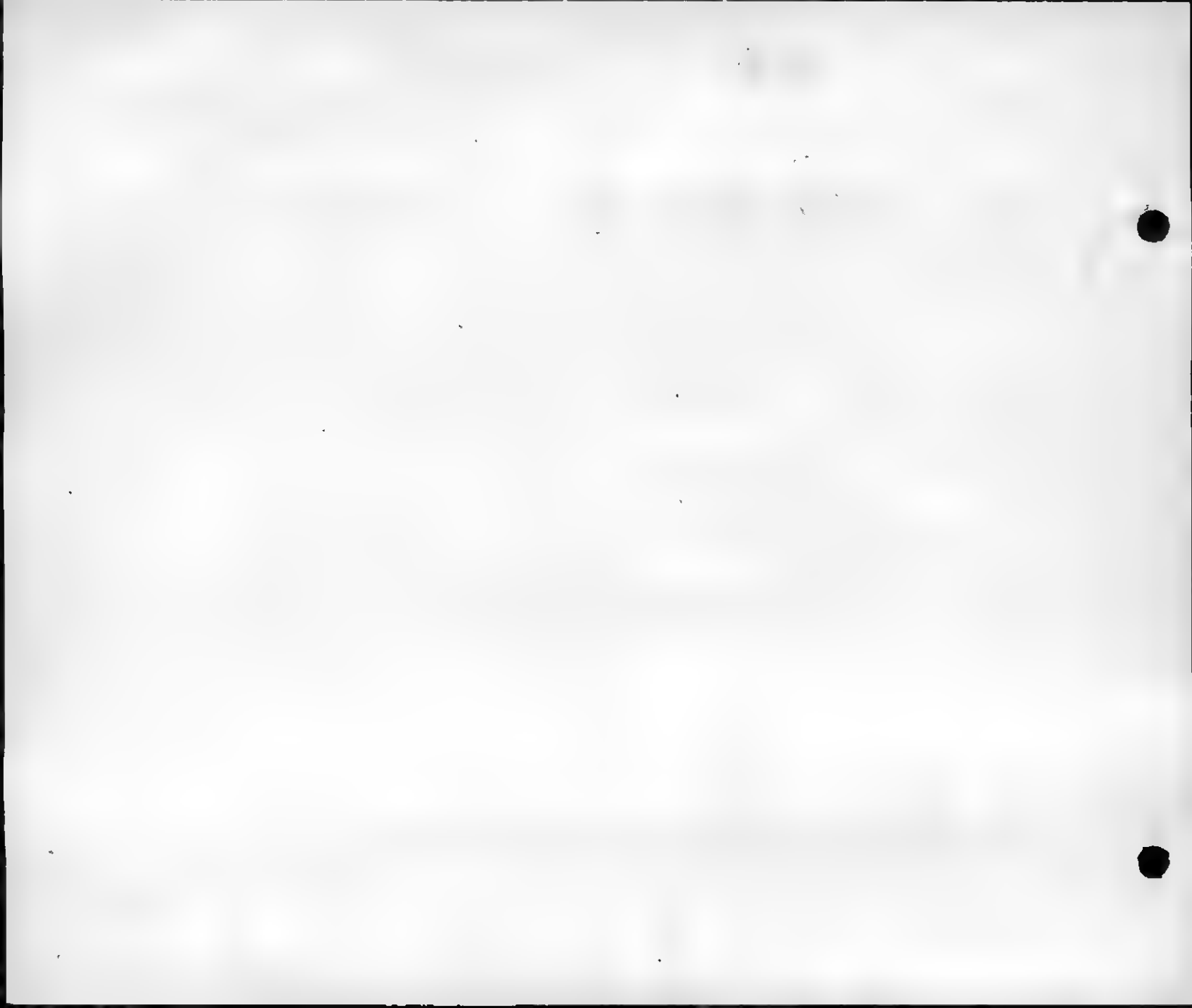
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

07779

7800

CERTIFICATE OF DEATH

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7909 Glenmont Road</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> d. STREET ADDRESS <u>7909 Glenmont Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>First Middle Last</u> <u>Richard R. Kizuka</u>				<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>18</u> Year <u>1960</u>							
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>June 7, 1948</u>		<b>9. AGE (In years lost birthday)</b> <u>12</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>12</u> Days <u>18</u> Hours <u>00</u> Min. <u>00</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore, Md</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Dr. Stuart Kizuka</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Beverly Kizuka</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO</b> <u>None</u>		<b>17. INFORMANT</b> <u>Dr. Stuart Kizuka</u>				<b>Address</b> <u>7909 Glenmont Road</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>200.1</u> DUE TO <u>U1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>None</u> DUE TO <u>None</u> (c) <u>None</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>None</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month <u>June</u> Day <u>19</u> Year <u>1960</u> Hour <u>a. m.</u> <u>19</u> p. m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>June 18, 1960</u>, to <u>June 18, 1960</u>, that (I) (we) last saw the deceased alive on <u>June 18, 1960</u>, and that death occurred at <u>3:00</u> M, from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>John A. Oakley</u>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>			<b>22b. DATE SIGNED</b>		
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>John A. Oakley</u>						<b>22d. ADDRESS</b> <u>1401 K... ..</u>					
<b>23a. BURIAL CREMATION REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>7/18/60</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Chick Adams</u>				<b>23d. LOCATION (City, town, or county)</b> (State) <u>Baltimore, Md</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joe Johnson</u>						<b>ADDRESS</b> <u>600 Kent Ave</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Arthur S. K...</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. K...</u>	
<b>DATE</b> <u>Jul 20 '60</u>						<b>DATE</b> <u>Jul 20 '60</u>					



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7801

## CERTIFICATE OF DEATH

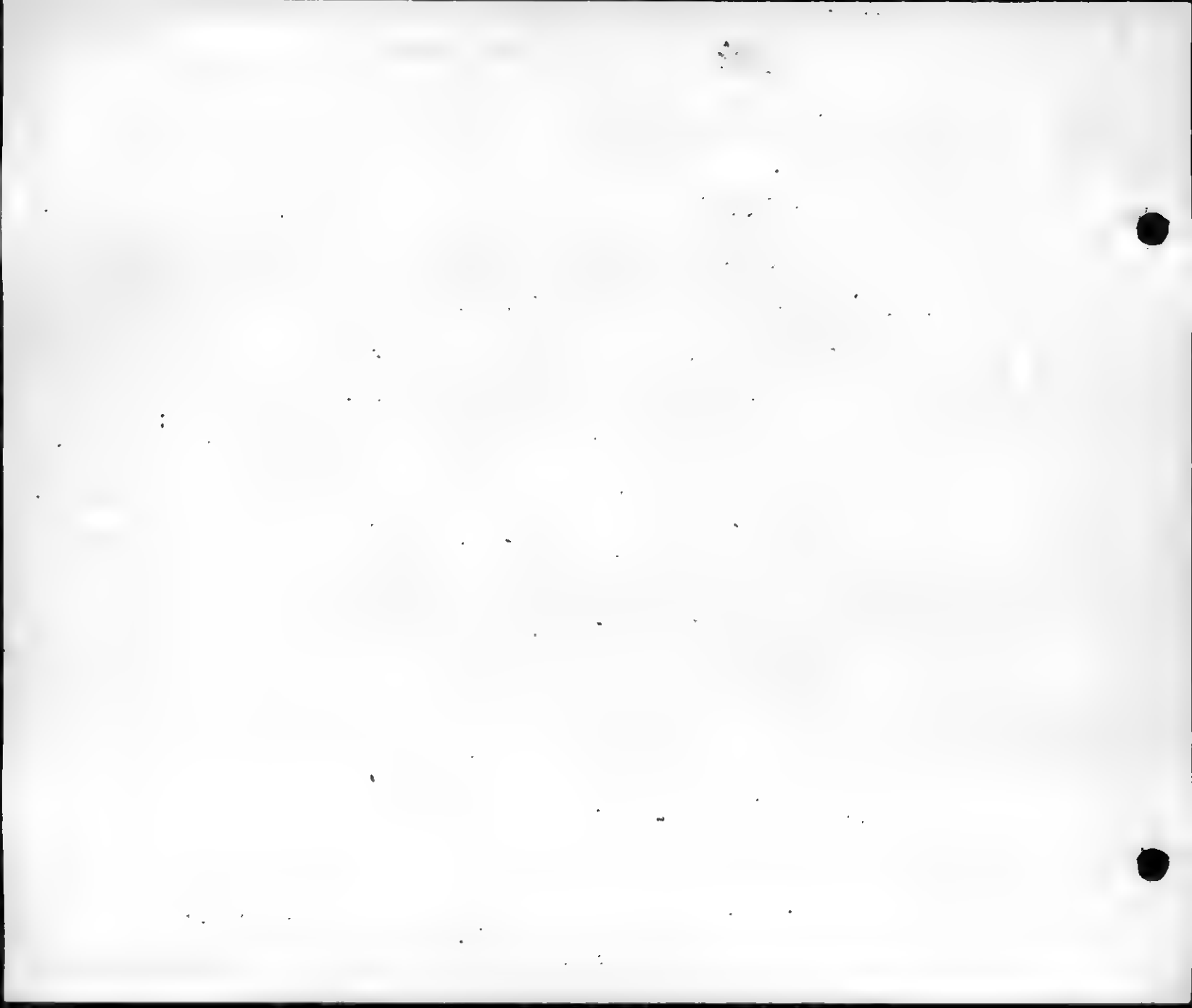
Reg. Dist. No.

07780

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FULLERTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FULLERTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4502 FORGE RD. #6, MD.</b>		e. STREET ADDRESS <b>15122 BELAIR RD.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANCES C. ROHE</b>		4. DATE OF DEATH Month Day Year <b>JULY 9 1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 26, 1888</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>	
11. BIRTHPLACE (State or foreign country) <b>AUSTRIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANK VANIK</b>		14. MOTHER'S MAIDEN NAME <b>JOSEPHINE UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>210-26-2706</b>	
17. INFORMANT <b>STANLEY REIDER</b>		Address <b>4502 FORGE RD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO (b) <b>Coronary arteriosclerosis</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>4 yrs</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized osteoarthritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-17</b> , 19 <b>59</b> , to <b>5-22</b> , 19 <b>60</b> that I last saw the deceased alive on <b>5-22</b> , 19 <b>60</b> , and that death occurred at <b>12:50 PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Seati Amoroso</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>JULY 12, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ST JOSEPH'S CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE CO MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sassahn Funeral Home</b>		24a. REC'D BY REGISTRAR <b>JUL 13 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

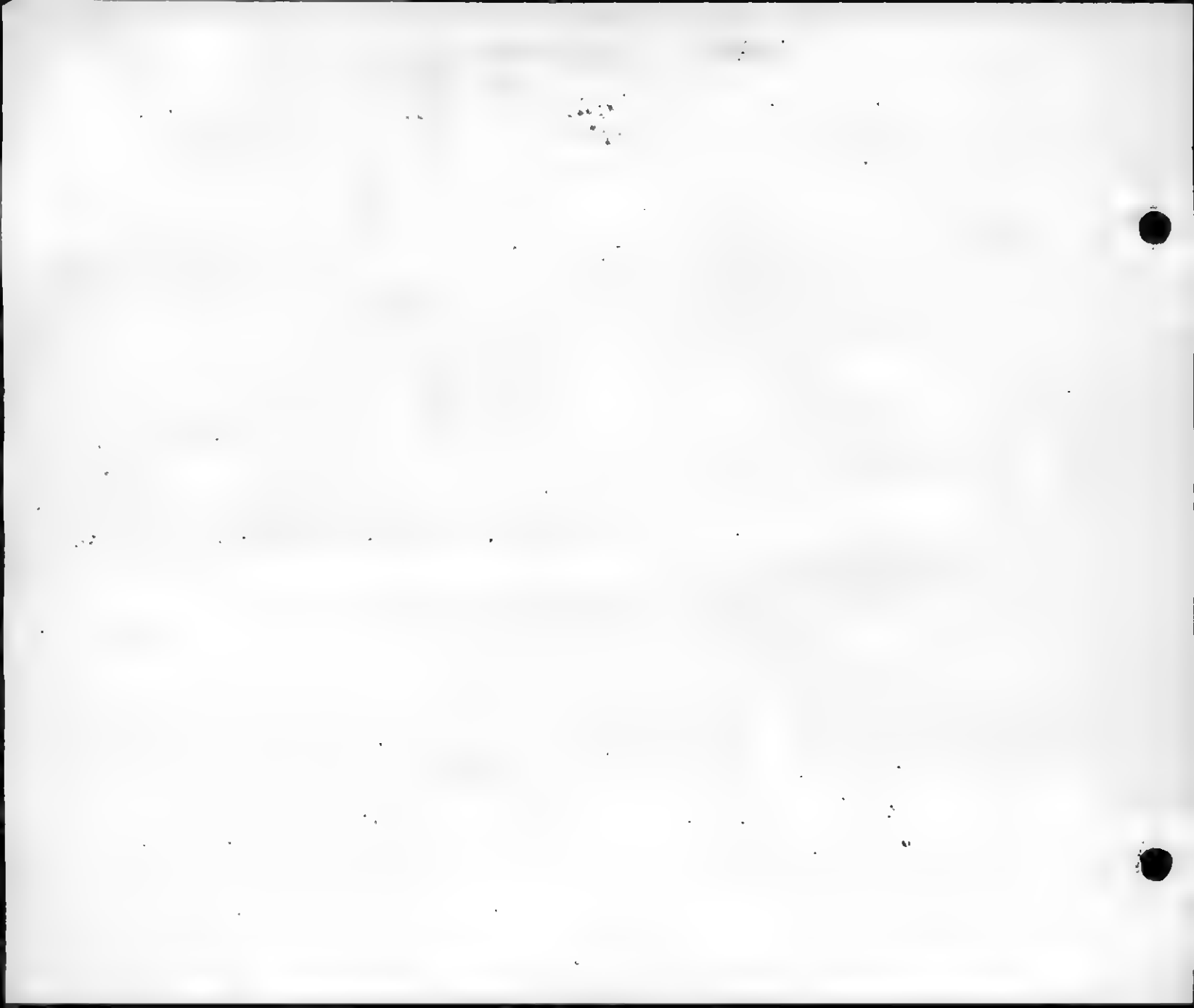
7802

## CERTIFICATE OF DEATH

Reg. Dist. No. 07781

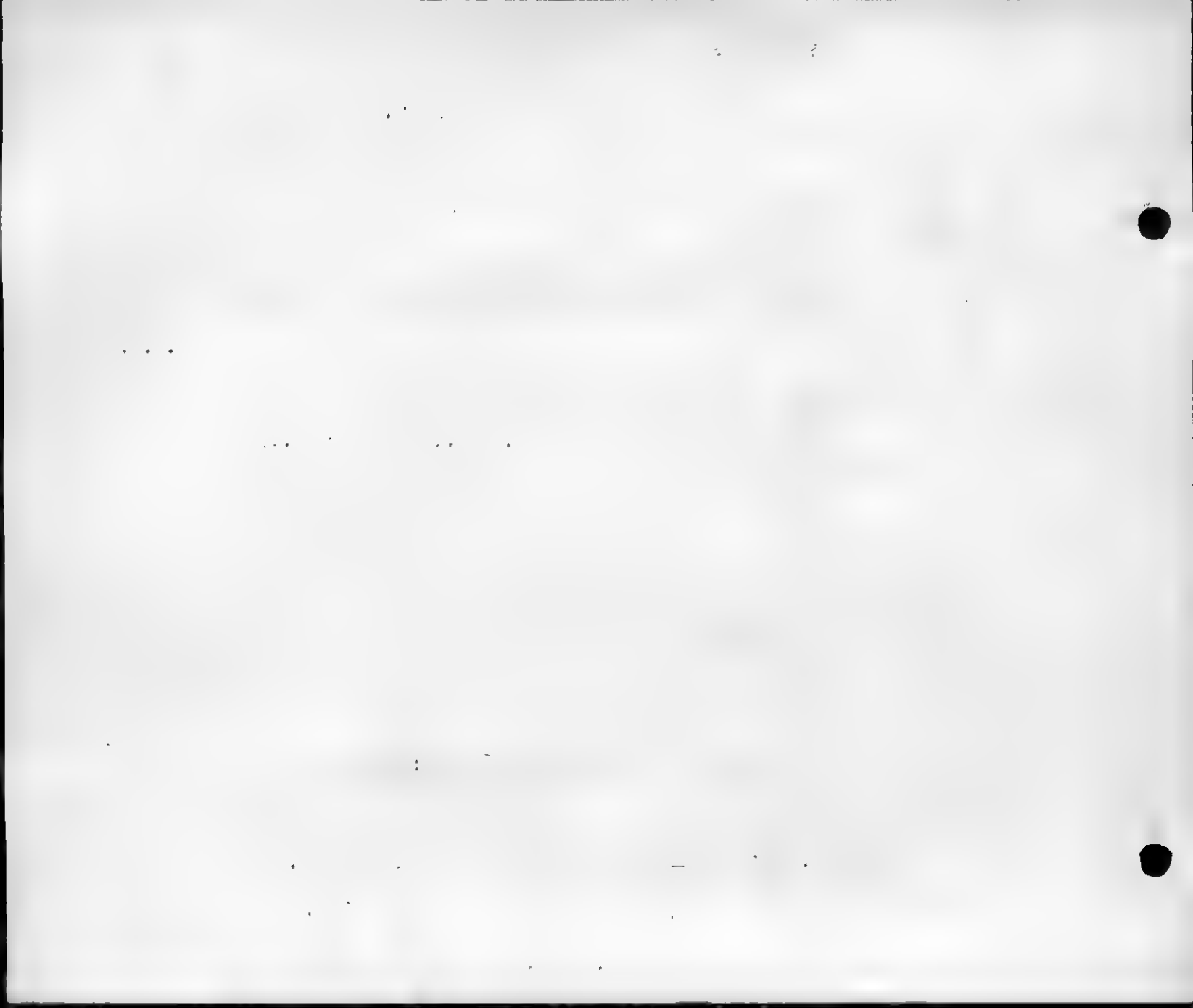
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>106 Rosewood Ave.</b>				e. STREET ADDRESS <b>106 Rosewood Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Harriet</b> Middle <b>B.</b> Last <b>Rowe</b>				4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>1960</b>			
5. SEX <b>F</b>	6. CO. OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 18, 1887</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <b>William T. Barker</b>				14. MOTHER'S MAIDEN NAME <b>Ida E. Brohann</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>----</b>		INFORMANT Address <b>Mr. John I. Rowe 106 Rosewood Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>490.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic hypertensive cardiovascular disease</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>5 months or less</b> <b>5 yrs +</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1955</b> 19 <b>7-16</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>23 June</b> , 19 <b>60</b> , and that death occurred at <b>4A</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1118 St Paul St, Baltimore 2, Maryland</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>John A. Nesbitt, Jr.</b> M.D. PHYSICIAN'S NAME (Type) <b>JOHN A. NESBITT, JR.</b>							
22a. BURIAL, CREMAT. OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-19-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Farley Funeral Home., Catonsville, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 21 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL CERTIFICATION

VR A15 (4)  
15M 9/59



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7675

## CERTIFICATE OF DEATH

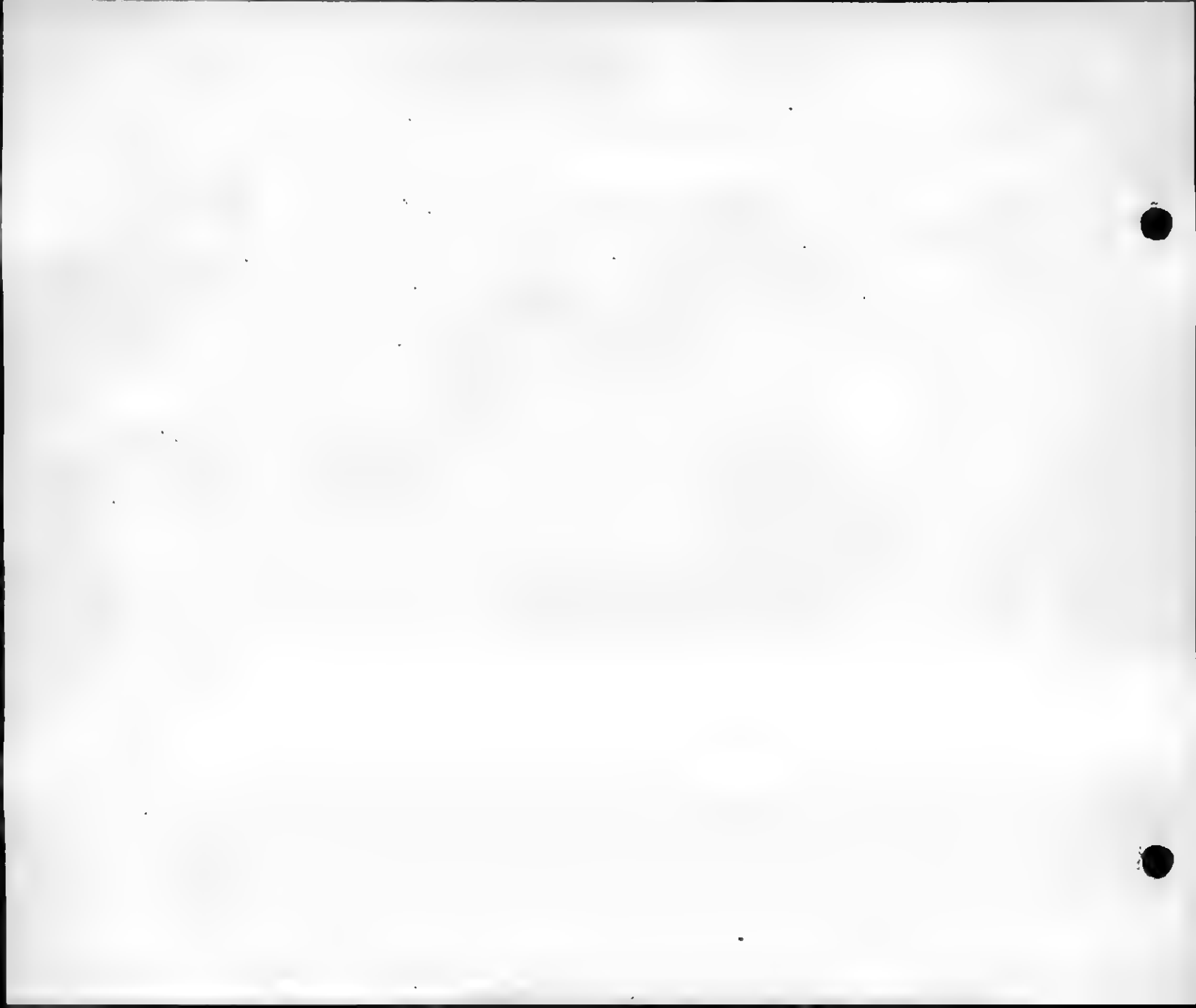
07783

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admision) a. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>		c LENGTH OF STAY IN lb <b>62 DUNDALK</b>	
d NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>6729 RAILWAY AVE. #22</b>		e STREET ADDRESS <b>6729 RAILWAY AVE. #22</b>	
f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>ANDREW</b> Middle <b>J.</b> Last <b>SANDERS</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>21</b> Year <b>1960</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 13, 1900</b>
9 AGE (In years last birthday) <b>60</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WEIGHER</b>	11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>JOHN SANDERS</b>		14. MOTHER'S MAIDEN NAME <b>KATHERINE KAUFMAN</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>MARIE H. SANDERS SAME.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>&gt; 71.1 GASTROENTERITIS ACUTE &amp; HEMORRHOIDAL</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 20, 1960</b> to <b>July 21, 1960</b> , that I last saw the deceased alive on <b>July 21, 1960</b> , and that death occurred at <b>1:20 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stephen C. Mochanich</b> M.D.		DATE SIGNED <b>7-22-60</b>	
PHYSICIAN'S NAME (Type) <b>S. C. MAKOWIAK</b>		<b>6714 HOLABIRD AVE BALTIMORE MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-23-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>7225 EASTERN BLVD., MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Geiler</b> ADDRESS <b>901 S. CONKLING ST. BALTO., 24, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 25 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

MEDICAL CERTIFICATION

Page 1  
The law requires that the death certificate be executed within 24 hours after death.  
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

7804

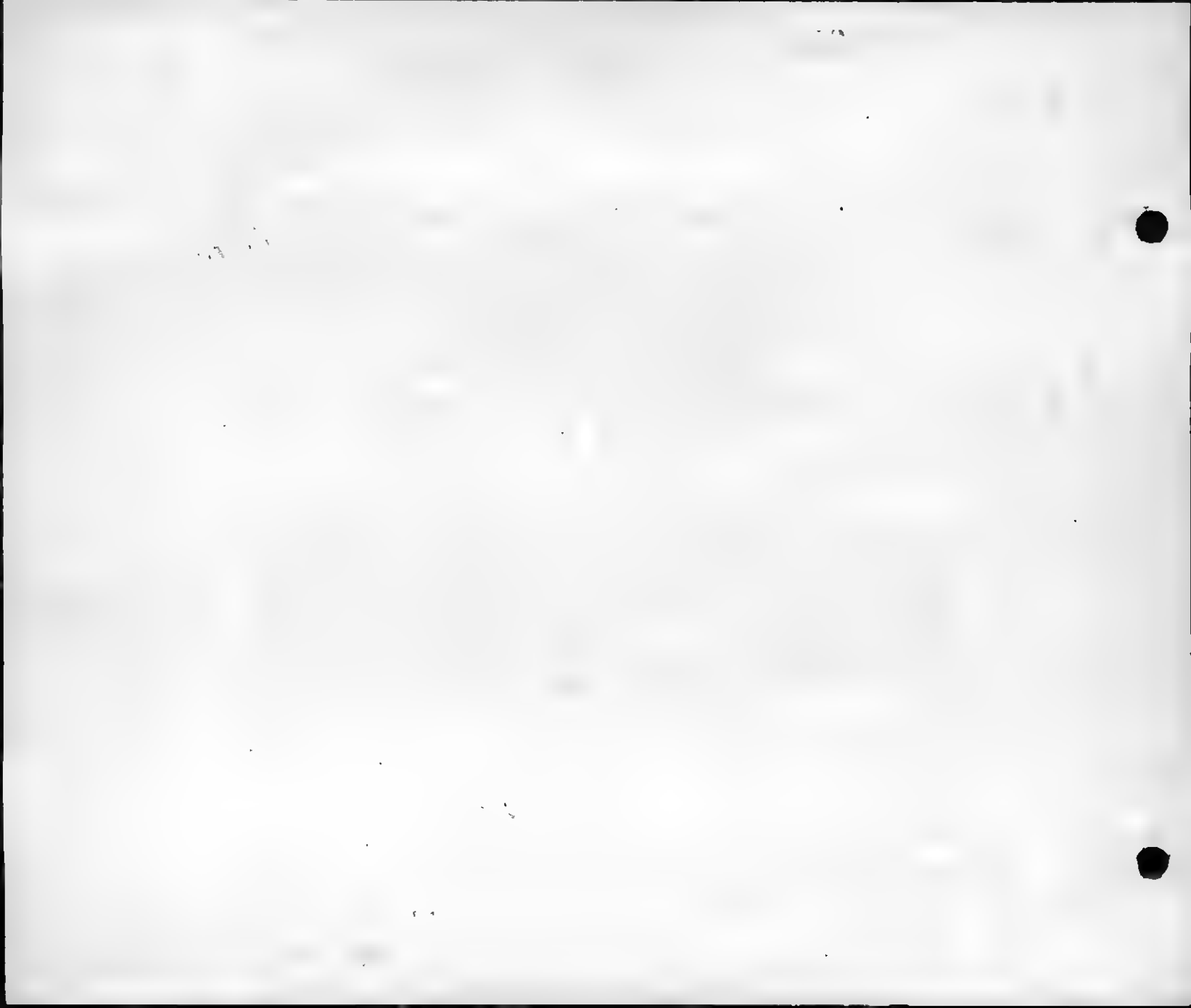
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 14 Filed 6/20/60 7/13/60 1 wk

07784

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> c. LENGTH OF STAY IN 1b <b>LIFE</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>215 BLENHEIM ROAD</b>		d. STREET ADDRESS <b>1 215 BLENHEIM ROAD</b>	
3 NAME OF DECEASED (Type or print) <b>EDITH</b> First <b>A.</b> Middle <b>SAUER</b> Last		4. DATE OF DEATH <b>July 8 1960</b> Month <b>July</b> Day <b>8</b> Year <b>1960</b>	
5 SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-19-1901</b> 9. AGE (In years last birthday) <b>59</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BALTIMORE</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES WATT</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(if yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>Mr. GEORGE F. SAUER SR.</b>	
17. INFORMANT <b>215 BLENHEIM RD BALT 12, MD</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abdominal carcinomatosis</b> DUE TO: Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <b>(b) Metastatic carcinoma right femur</b> DUE TO: <b>(c) Adenocarcinoma sigmoid colon</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>22 Mar 1957</b> to <b>6 July 1960</b> , that (I) (we) last saw the deceased alive on <b>7 July 1960</b> , and that death occurred at <b>7 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John W. Barnaby</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>JOHN W. BARNABY</b>		22d. ADDRESS <b>1531 E. 1st Ave.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>ENTOMBMENT</b>		23b. DATE THEREOF <b>JULY 11, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>BALTIMORE COUNTY, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY W. JENKINS &amp; SONS Co</b>		25a. REC'D BY REGISTRAR <b>DATE 12 12 60</b>	
ADDRESS <b>4905 YORK RD. BALT 12.</b>		25b. REGISTRAR'S SIGNATURE <b>Robert E. Thomas</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

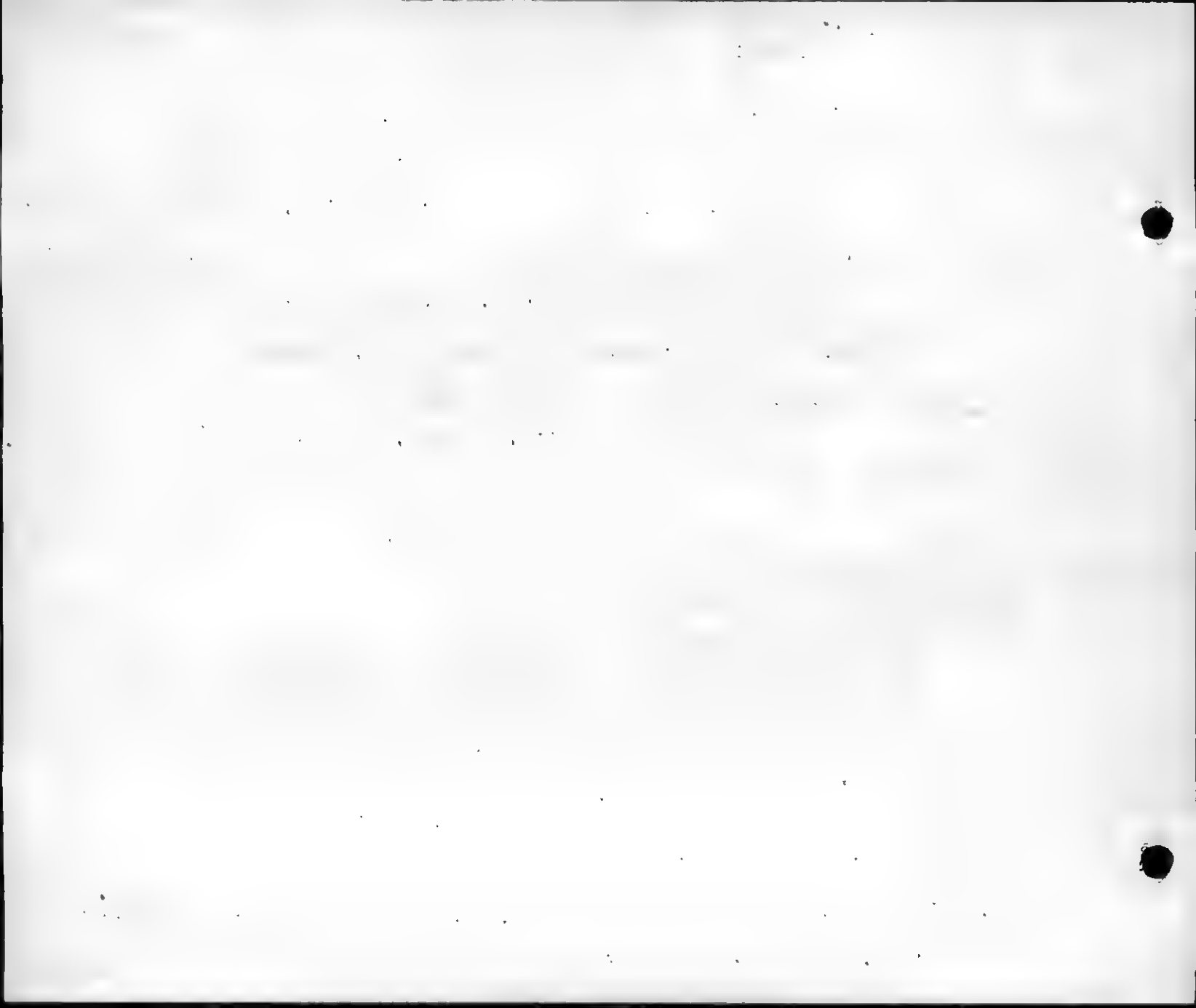
7805

## CERTIFICATE OF DEATH

Reg. Dist. No.

07785

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3800 Taylor Avenue n</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mr. John Albert Schafer</i>		4. DATE OF DEATH <i>July 19, 1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 27, 1878</i>
9. AGE (In years last birthday) <i>81</i> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i>	
11. BIRTHPLACE (State or foreign country) <i>Hartford Co. Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Schafer</i>		14. MOTHER'S MAIDEN NAME <i>Ellen</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Informant</i>	
17. ADDRESS <i>Mrs. Anna B. Schafer 3800 Taylor Ave.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary exclusion</i>			
(b) <i>Cerebrovascular C.V.D.</i>			
(c) <i>Combined thrombotic episodes</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1950</i> to <i>July 19, 1960</i> , that I last saw the deceased alive on <i>July 19, 1960</i> , and that death occurred at <i>1 P. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Henry Huase M.D.</i>		DATE SIGNED <i>2926 S. Cold Spring Lane</i>	
PHYSICIAN'S NAME (Type) <i>J. Henry Huase M.D.</i>		<i>Baltimore, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/22/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		24a. REC'D BY REGISTRAR <i>JUL 21 '60</i>	
ADDRESS <i>5305 Hartford Road #14</i>		24b. REGISTRAR'S SIGNATURE <i>C. J. Ruck</i>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7806

## CERTIFICATE OF DEATH

Reg. Dist. **187286**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b <b>6 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stella Maris Hospice</b>				e. STREET ADDRESS <b>710 E. 41st Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Jane</b> Last <b>Schanberger</b>				4. DATE OF DEATH Month <b>7</b> Day <b>21</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/17/1875</b>		9. AGE (In years last birthday) <b>84</b> yrs	IF UNDER 1 YEAR Months <b>2</b> Days <b>1</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Joseph Roston</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Cooney</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>20 yrs</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1955</b> to <b>July 21, 1960</b> that I last saw the deceased alive on <b>July 20, 1960</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE/SIGNED <b>7/21/60</b>							
ACTUAL SIGNATURE <b>Charles F. O'Donnell M.D.</b>				PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell- M.D.</b>			
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>7-23-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Dale Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest J. Rick</b>				ADDRESS <b>5305 Bayford</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 22 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

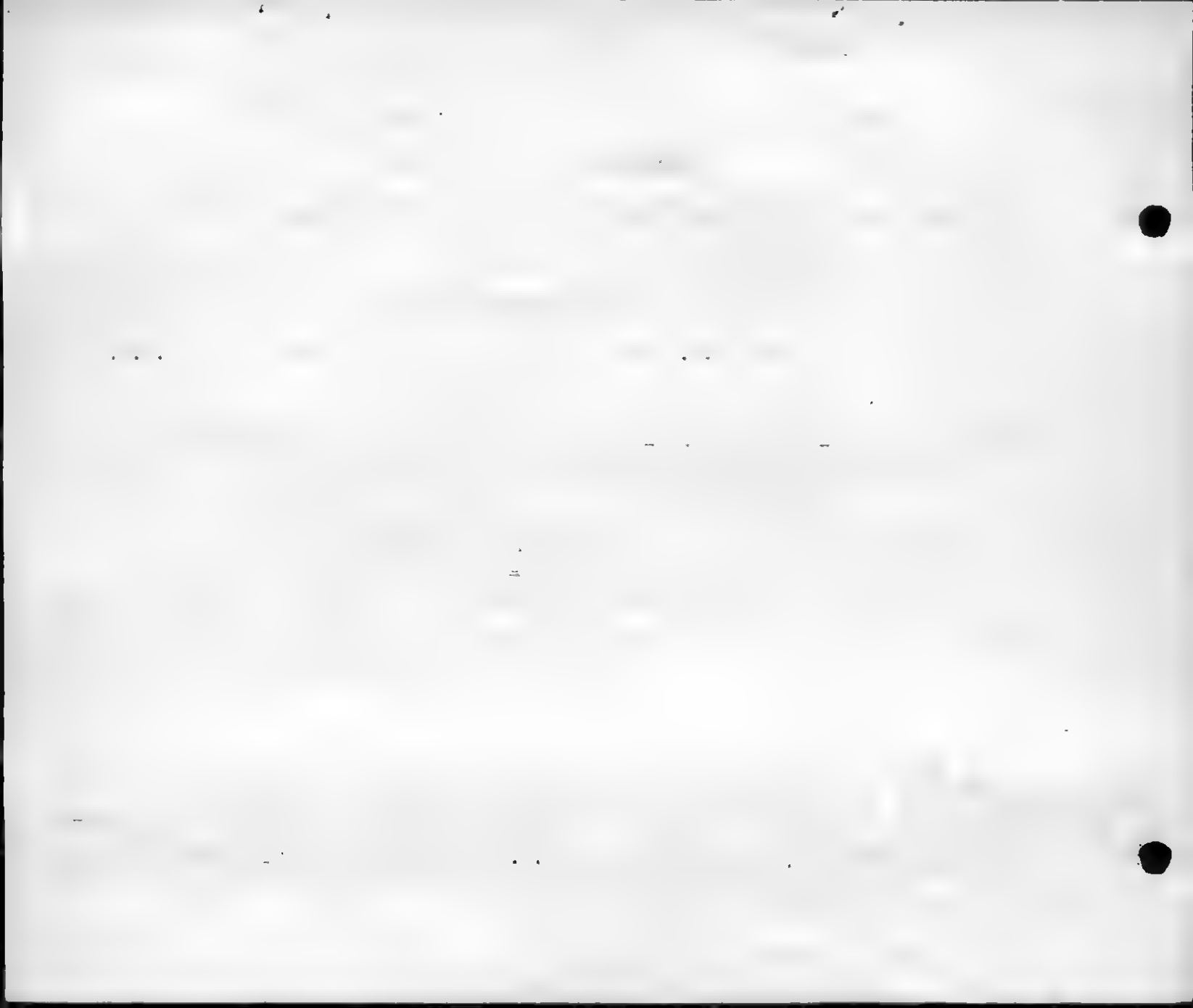
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15M 9/59

7807

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

07787

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>13 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. STREET ADDRESS <b>3716 TOWANDA AVENUE</b>			
3. NAME OF DECEASED (Type or print) First <b>RALPH</b> Middle <b>M.</b> Last <b>SCHAPIRO</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>8</b> Year <b>19 60</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 3, 1891</b>	9. AGE (In years last birthday) <b>69</b> yrs	10. UNDER 1 YEAR Months Days Hours Min		11. UNDER 24 HRS
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAIL CARRIER (RETIRED)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. POSTAL SERVICE BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SOLOMON I. SCHAPIRO</b>				14. MOTHER'S MAIDEN NAME <b>IDA ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES WW-1</b>		16. SOCIAL SECURITY NO. <b>217-40-3002</b>		17. INFORMANT <b>CLIN REC VAH BALTIMORE MD FT HOWARD DIVISION</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ASTROCYTOMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JUNE 20, 1960</b> , to <b>JULY 8, 1960</b> , that <input checked="" type="checkbox"/> (we) lost the deceased alive on <b>JULY 8, 1960</b> , and that death occurred at <b>5:35 PM</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>Philip J. Jensen</b>				22b. DATE SIGNED <b>7-8-60</b>		22c. PHYSICIAN'S NAME (Type) <b>PHILIP J. JENSEN</b>	
22d. ADDRESS <b>M.S. VAH BALTIMORE 18 MD-FT HOWARD DIVISION</b>							
23a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7/10/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BOBERISKER BENEFICIAL CIRCLE CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>SoL LEVINSON &amp; BROS INC</b>				25a. REC'D BY REGISTRAR <b>6010 REISTERSTOWN RD BALTIMORE 15 MD</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>	



# STATE HEALTH DEPT.

TO REGISTER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

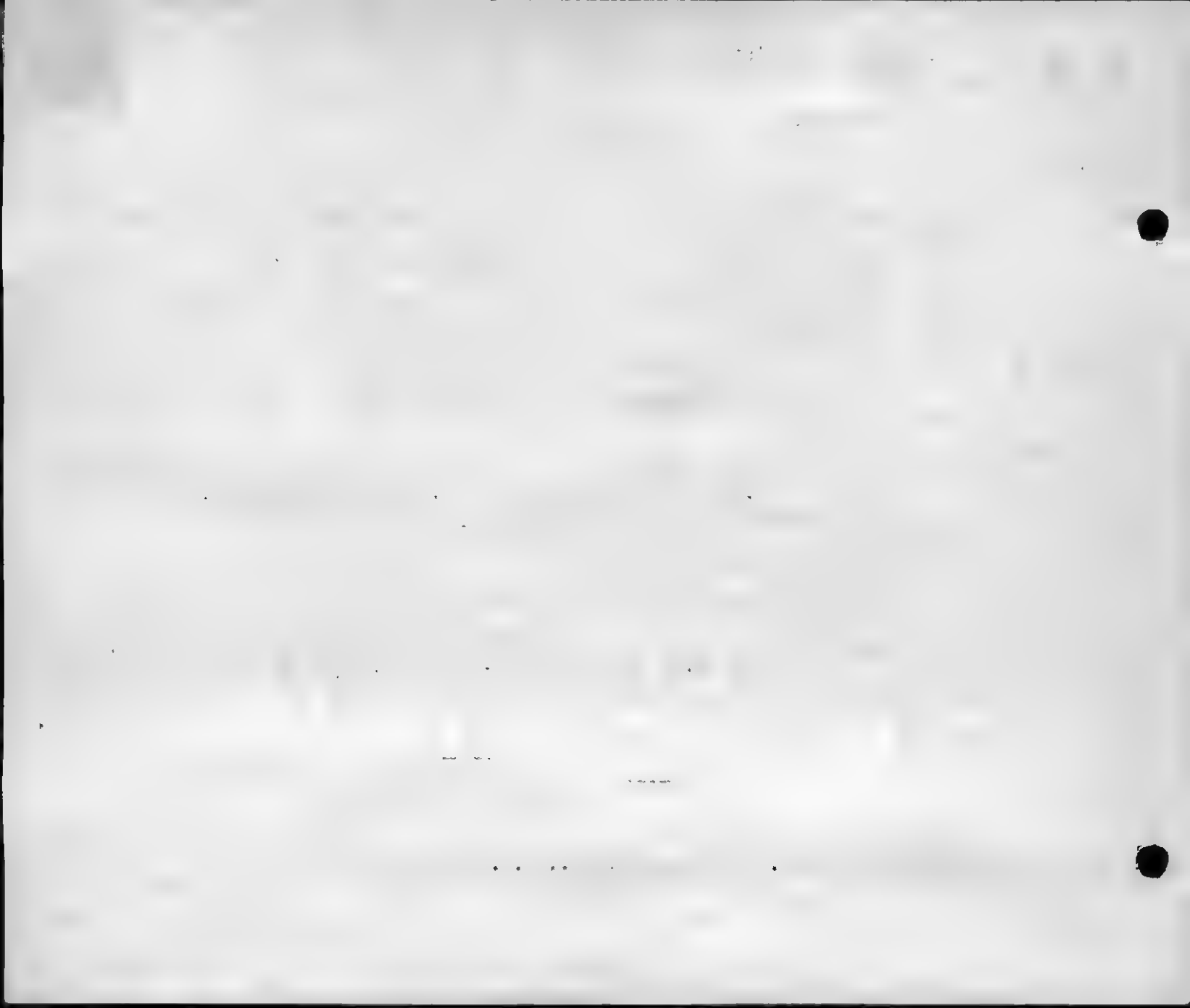
7808

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Flimg 268 8-4-60 et

07788

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Baltimore-Rural</b>		b. COUNTY <b>Baltimore 6</b>	
c. LENGTH OF STAY IN b <b>50 Hawthorne Road</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Martin Span</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOSEPH GEORGE SELESKY</b>		4. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>1960</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 3, 1939</b>	
9. AGE (In years last birthday) <b>21 yrs.</b>		10. IF UNDER 1 YEAR Months <b>21</b> Days <b>27</b> Hours <b>1960</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipe Fitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ed. Tech Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Allison, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph George Selesky</b>		14. MOTHER'S MAIDEN NAME <b>Grace Newcomer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes U.S.A.R.</b>		16. SOCIAL SECURITY NO. <b>1-23-60</b>	
17. INFORMANT <b>Joseph George Selesky</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple fractures of skull, trunk and extremities</b> <b>with massive internal injuries and hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Driver of auto in auto-truck collision, thrown out of car and run over by another car</b> (c) <b>Due to</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18) <b>Driver of auto in auto-truck collision, thrown out of car and run over by another car</b> 20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Road</b> 20e. (City or town) (County) (State) <b>Baltimore Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
23. ACTUAL SIGNATURE <b>W. Bradley King, Jr., M.D.</b> DATE SIGNED <b>7/27/60</b>			
24. EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>			
25. BURIAL, CREMATION, REMOVAL (Specify) <b>7-28-60</b>			
26. DATE THEREOF <b>7-28-60</b>			
27. NAME OF CEMETERY OR CREMATORY <b>Lafayette Memorial PK. Brier Hall, Pa.</b>			
28. LOCATION (City, town, or country) (State) <b>1217 St. Paul ST. Baltimore Md.</b>			
29. FUNERAL DIRECTOR <b>Wm Cook Funerals</b>			
30. REC'D BY REGISTRAR <b>AUG 1 '60</b>			
31. REGISTRAR'S SIGNATURE <b>Colman S. K...</b>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7676

Item 6 - 1-10-67 1-10-67 et

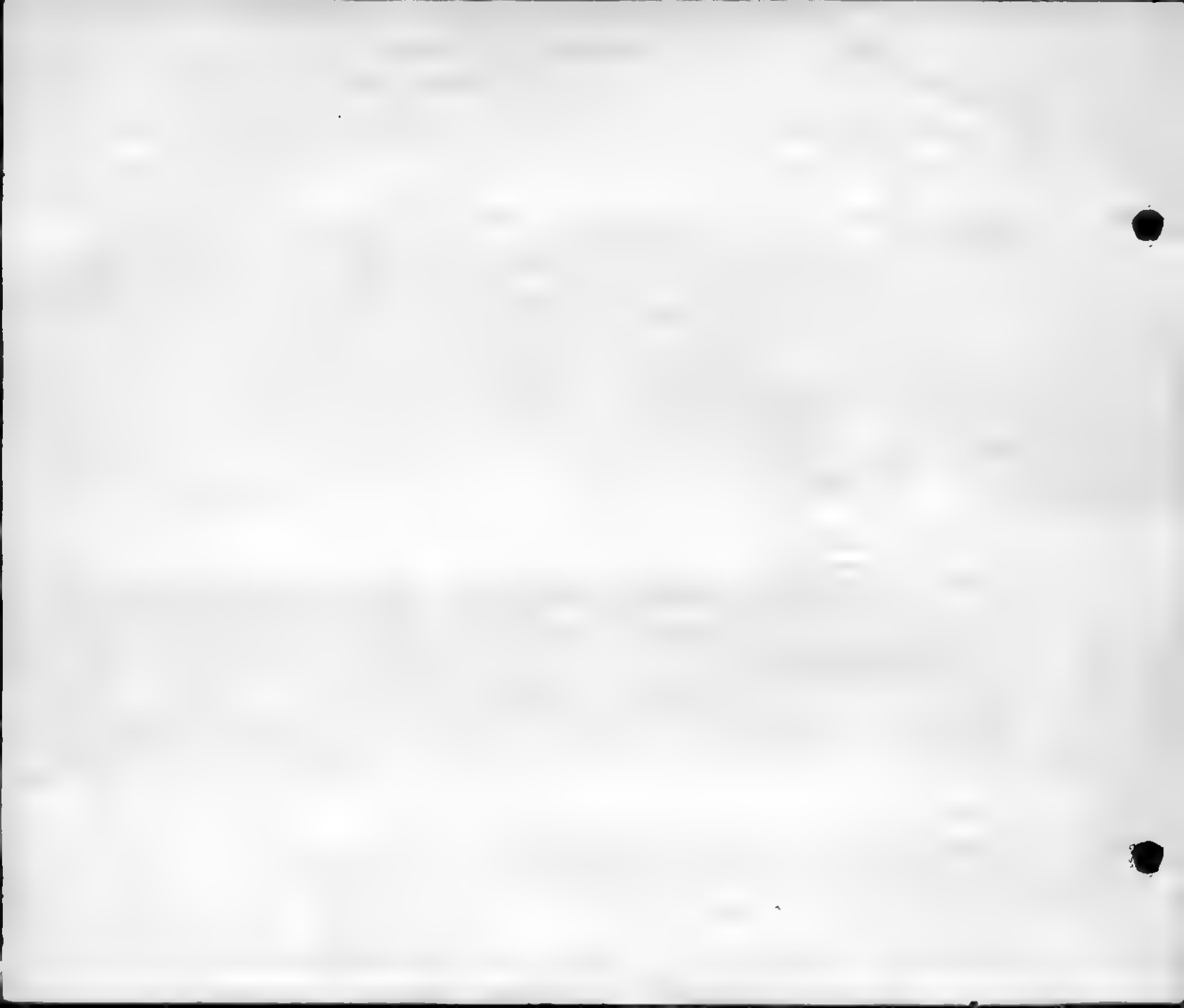
CERTIFICATE OF DEATH

Reg. Dist. No. 07789

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>NORTH Carolina</u> b. COUNTY <u>Halifax</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 22</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Halifax</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>123 Cypress ST</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Amos</u> Middle <u>Shearin</u> Last <u>Shearin</u>				4. DATE OF DEATH Day <u>July</u> Month <u>22</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 15, 1865</u>	9. AGE (In years last birthday) <u>95</u> yrs.	10. UNDER 1 YEAR Months <u>4</u> Days <u>7</u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sanitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Court House</u>		11. BIRTHPLACE (State or foreign country) <u>Warren, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Simon Pugh</u>				14. MOTHER'S MAIDEN NAME <u>Susan ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT <u>Susie Leak 1125 N. Strickland St, Baltimore</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Nephritis</u> DUE TO (c) <u>Pneumonia &amp; Senility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>2 yrs</u> <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <u>19</u> Day <u></u> Year <u></u> Hour <u></u> o. m. <u></u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u></u>				20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>51</u> , to <u>July 22</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>July 22</u> , 19 <u>60</u> , and that death occurred at <u>8 A</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>140 Oak Ave.</u> DATE SIGNED <u>July 23, 1960</u>							
ACTUAL SIGNATURE <u>William C. Wade</u>				M.D. <u>140 Oak Ave.</u>			
PHYSICIAN'S NAME (Type) <u>William C. Wade, M.D.</u>				<u>Dundalk 22, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-26-60</u>		<u>New Cemetery</u>		<u>Halifax, N. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. Jackson</u>				ADDRESS <u>Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 25 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7684

CERTIFICATE OF DEATH

07790

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admittance) STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abertus</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abertus</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1300 Poplar Ave</u>		d. STREET ADDRESS <u>Poplar Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Charles T. Shek</u> First Middle Last		4. DATE OF DEATH <u>July 2, 1960</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/19/1867</u>
9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>York Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederick G. Shek</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Kease</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mary M. Shek</u> Address <u>1300 Poplar Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Cardiac failure, chronic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, general</u> DUE TO (c) <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>?</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 15, 1960</u> to <u>July 2, 1960</u> , that I last saw the deceased alive on <u>July 1, 1960</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. P. Williamson</u> M.D.		ADDRESS (Street, city or town, state) <u>3534 Linmon Ave (29)</u> DATE SIGNED <u>7/3/60</u>	
PHYSICIAN'S NAME (Type) <u>E. P. WILLIAMSON II M.D.</u>			
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>7-5-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Louder Park</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Hipbert</u> ADDRESS <u>1300 Euterus Pl.</u>		24a. REC'D BY REGISTRAR <u>5 '60</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

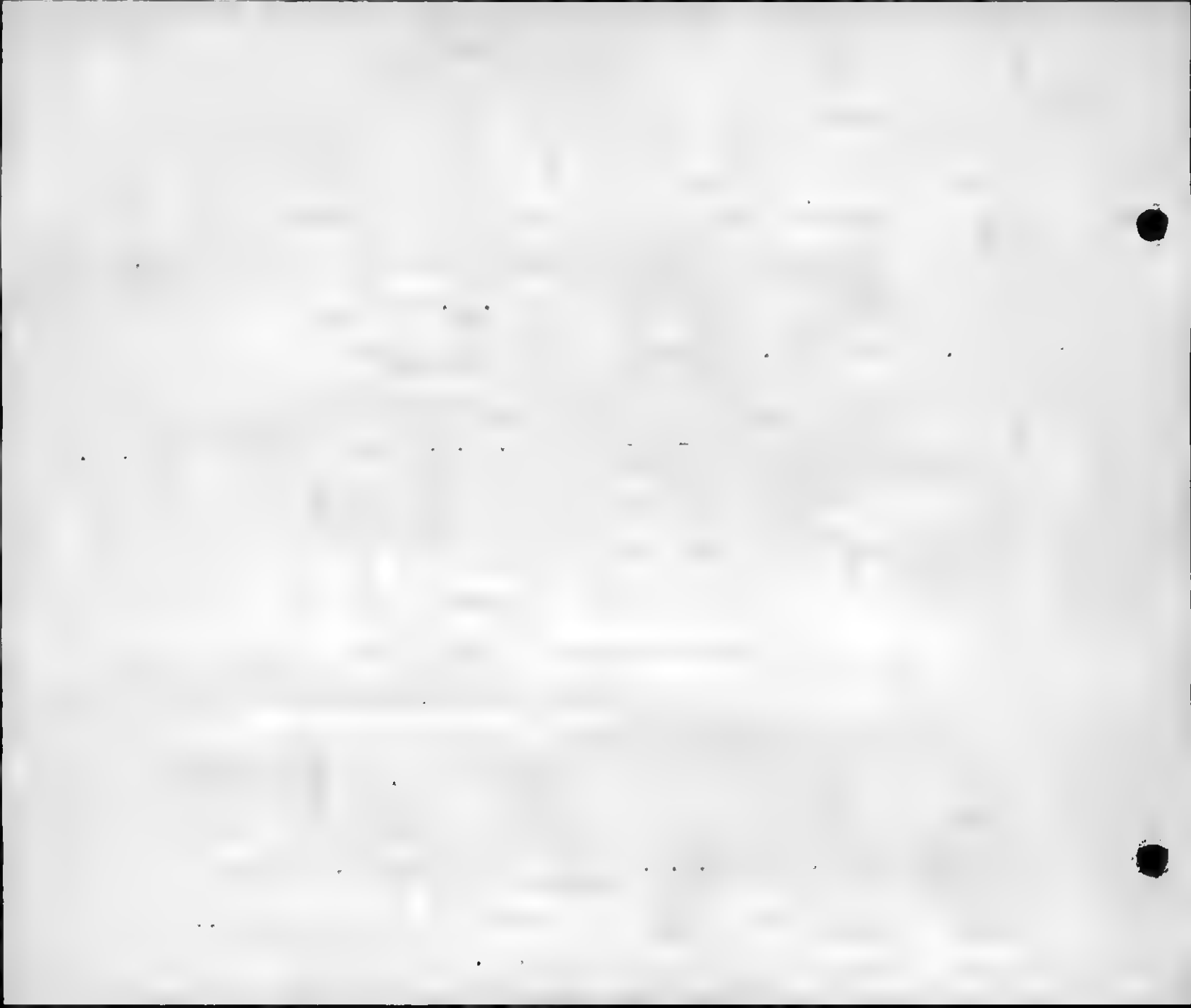
Reg. Dist. No.

07791

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>		c. LENGTH OF STAY IN 1b <b>Dundalk (22)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>30 Flagship Road</b>		d. STREET ADDRESS <b>30 Flagship Road</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>OSCAR</b> Last <b>SKILES</b>		4. DATE OF DEATH Month <b>July</b> Day <b>8th</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 12, 1895</b>
9. AGE (in years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst. Chemical Eng.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Frank Skiles</b>	
14. MOTHER'S MAIDEN NAME <b>Rachel Jackson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO <b>213-079-372</b>		17. INFORMANT <b>Mrs. A.N. Mumper</b> Address <b>116 Bayside Drive Baltimore 22, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Occ. lesion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7-1</b> , 19 <b>60</b> , to <b>7-8</b> , 19 <b>60</b> ; that I last saw the deceased alive on <b>7-1</b> , 19 <b>60</b> , and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2 Kinship Road Baltimore 22, Maryland</b> DATE SIGNED <b>7/11/60</b>			
ACTUAL SIGNATURE <b>Jack C. Collins</b> M.D.		22. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	
PHYSICIAN'S NAME (Type) <b>Jack C. Collins, M.D.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/12/60</b>	24a. REC'D BY REGISTRAR <b>Jul 12 '60</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Dundalk 22, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



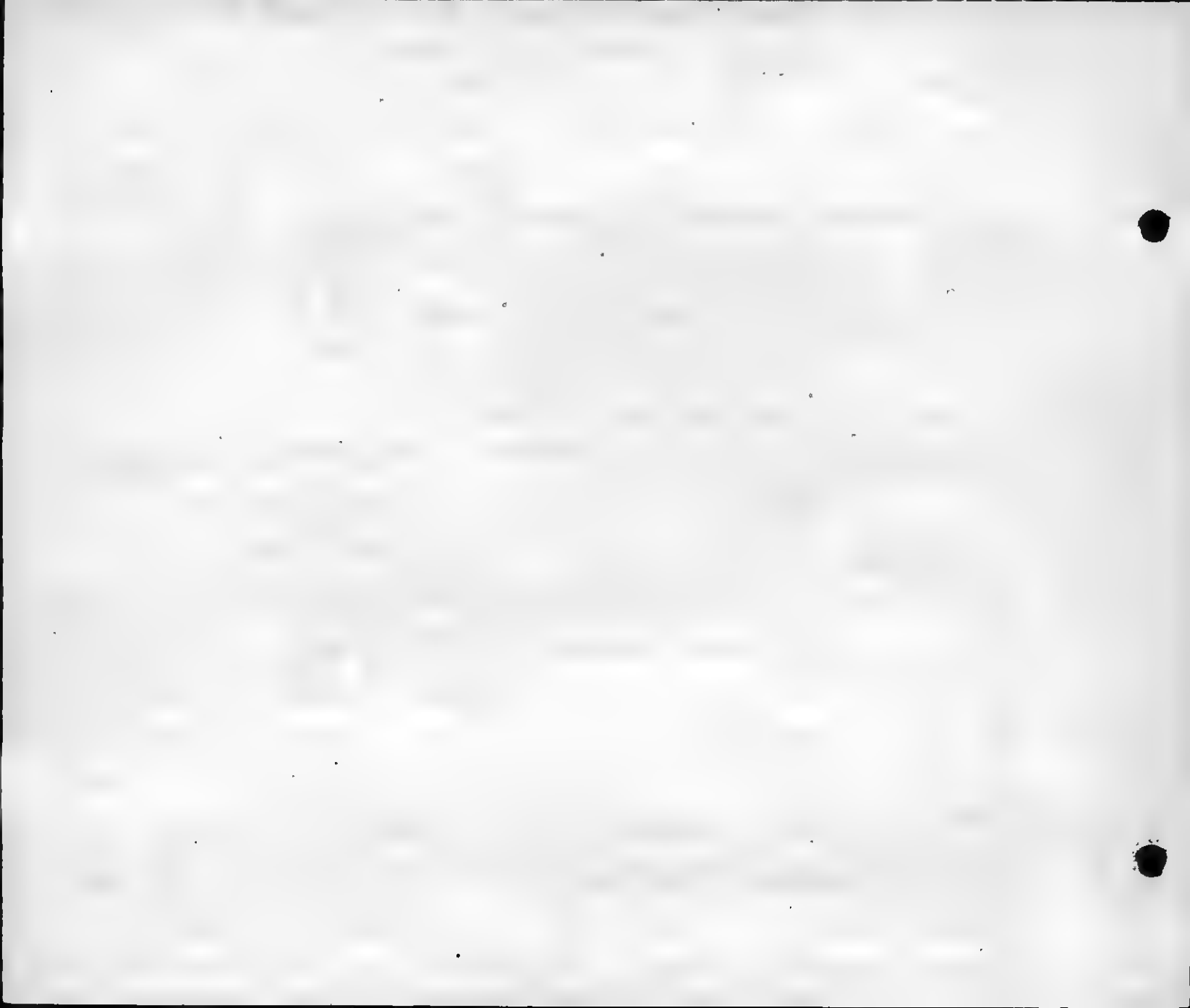
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1422 Burton Ave</u>		d. STREET ADDRESS <u>1422 Burton Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>W.</u> Last <u>Slaymaker</u>		4. DATE OF DEATH <u>July 31, 1960</u> Day <u>31</u> Month <u>July</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 30, 1924</u>
9. AGE (In years last birthday) <u>35</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Black and Decker</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William A. Slaymaker</u>		14. MOTHER'S MAIDEN NAME <u>Esther Laird</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWII</u>		16. SOCIAL SECURITY NO. <u>Edna J. Slaymaker-1422 Burton Ave. Luth.</u>	
17. INFORMANT <u>Edna J. Slaymaker-1422 Burton Ave. Luth.</u>		Address <u>Luth.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GLIOMA, FRONTAL, MALIGNANT</u> <u>193.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUN 1960</u> to <u>JULY 1960</u> , that I last saw the deceased alive on <u>JULY 28, 1960</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Timonium, Md</u> DATE SIGNED <u>8-1-60</u>			
ACTUAL SIGNATURE <u>William A. Pillsbury</u> M.D.		PHYSICIAN'S NAME (Type) <u>William A. Pillsbury</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/4/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Timonium, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Towson, Inc.</u> ADDRESS <u>York Rd. Towson 4, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 3 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneiss</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



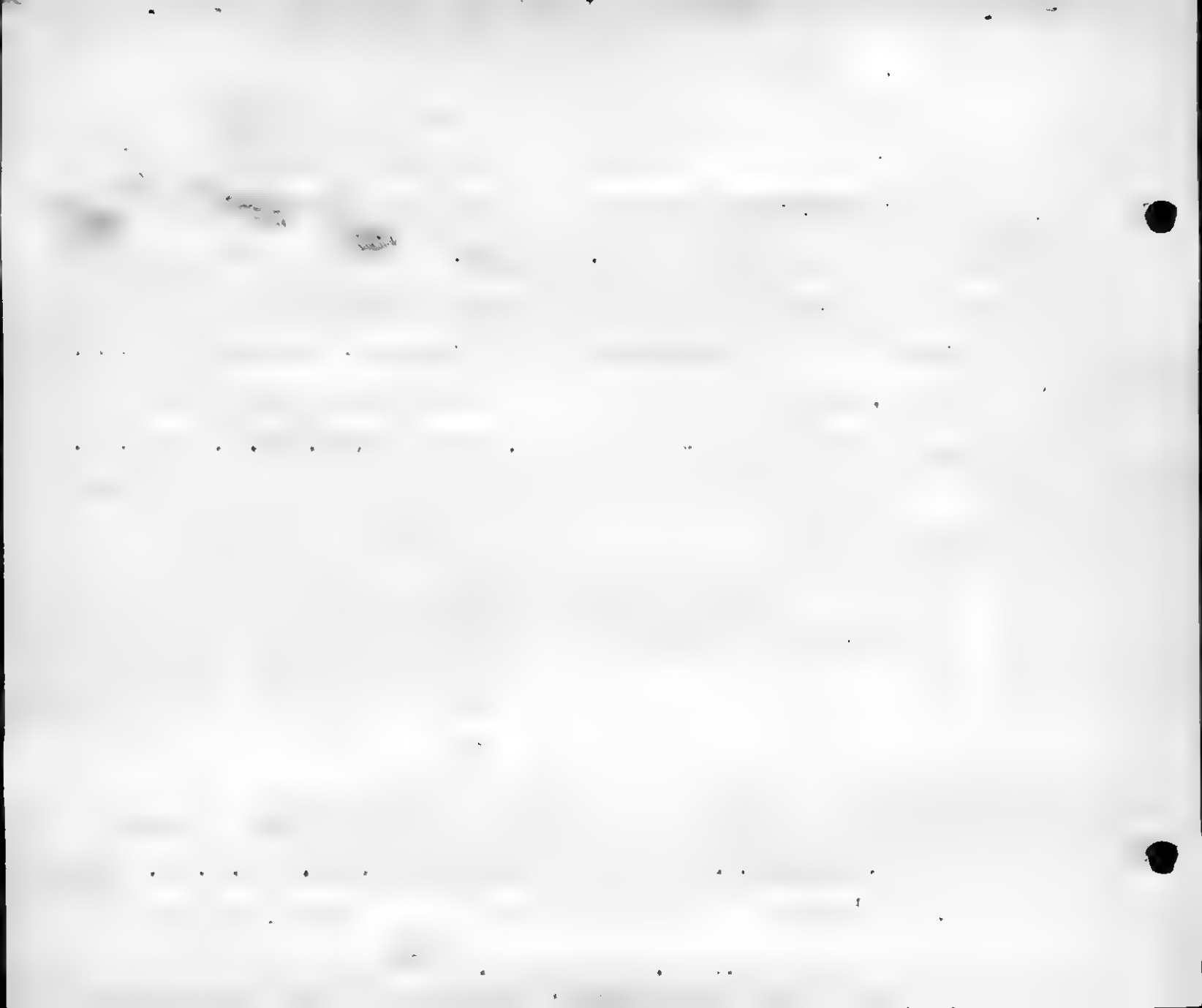
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**DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

07793

7810

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>33 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>902 Harlem Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PERCY</b> Middle <b>S.</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>31</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 21, 1894</b> 9. AGE (in years last birthday) <b>66</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Meat Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Westchester, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel H. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Alice (Maiden Name Unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service, <b>WW I</b> )		16. SOCIAL SECURITY NO <b>217-16-4587</b>	
17. INFORMANT <b>Clin. Records, Vet. Adm. Hosp. Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> <b>493 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CARCINOMA OF STOMACH</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>June 28</b> 19 <b>60</b> to <b>July 31</b> 19 <b>60</b> , that <b>10</b> (we) last saw the deceased alive on <b>July 31</b> 19 <b>60</b> and that death occurred at <b>4:40 AM</b> on the date stated above.			
22a. SIGNATURE <b>John K. Ebling</b> M.D.		22b. DATE SIGNED <b>7/31/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN K. EBLING, M.D.</b>		22d. ADDRESS <b>Veterans Adm. Hosp. Balto. Md. Ft. Howard Div</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/3/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Roland Brown</b>		25a. REC'D BY REG. STRAR <b>4</b> 25b. REGISTRAR'S SIGNATURE <b>Robert P. Kraus</b>	
ADDRESS <b>Baltimore, Md.</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 4 with the State Board of Health after death. or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS. A15ME  
5M 7/59

item 18 Film 268 8-17-60

7811

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07794

1. PLACE OF DEATH  
a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN TB 2Y 10M 23D d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)  
a. STATE Maryland b. COUNTY Pr. Georges Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn d. STREET ADDRESS 8615 Rhode Island Avenue

3. NAME OF DECEASED (Type or print) EDWARD George SNYDER

4. DATE OF DEATH July 10, 1960

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH Dec 19, 1930 9. AGE (In years last birthday) 29 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none 10b. KIND OF BUSINESS OR INDUSTRY none 11. BIRTHPLACE (State or foreign country) Md 12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME George Snyder 14. MOTHER'S MAIDEN NAME Anna Hanna

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. none 17. INFORMANT George Snyder same as no 2 Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic bilateral pneumonia with foci of acute pneumonia complicating mental deficiency.  
DUE TO (b) Chronic bilateral pneumonia with foci of acute pneumonia complicating mental deficiency.  
DUE TO (c) Chronic bilateral pneumonia with foci of acute pneumonia complicating mental deficiency.  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic bilateral pneumonia with foci of acute pneumonia complicating mental deficiency.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

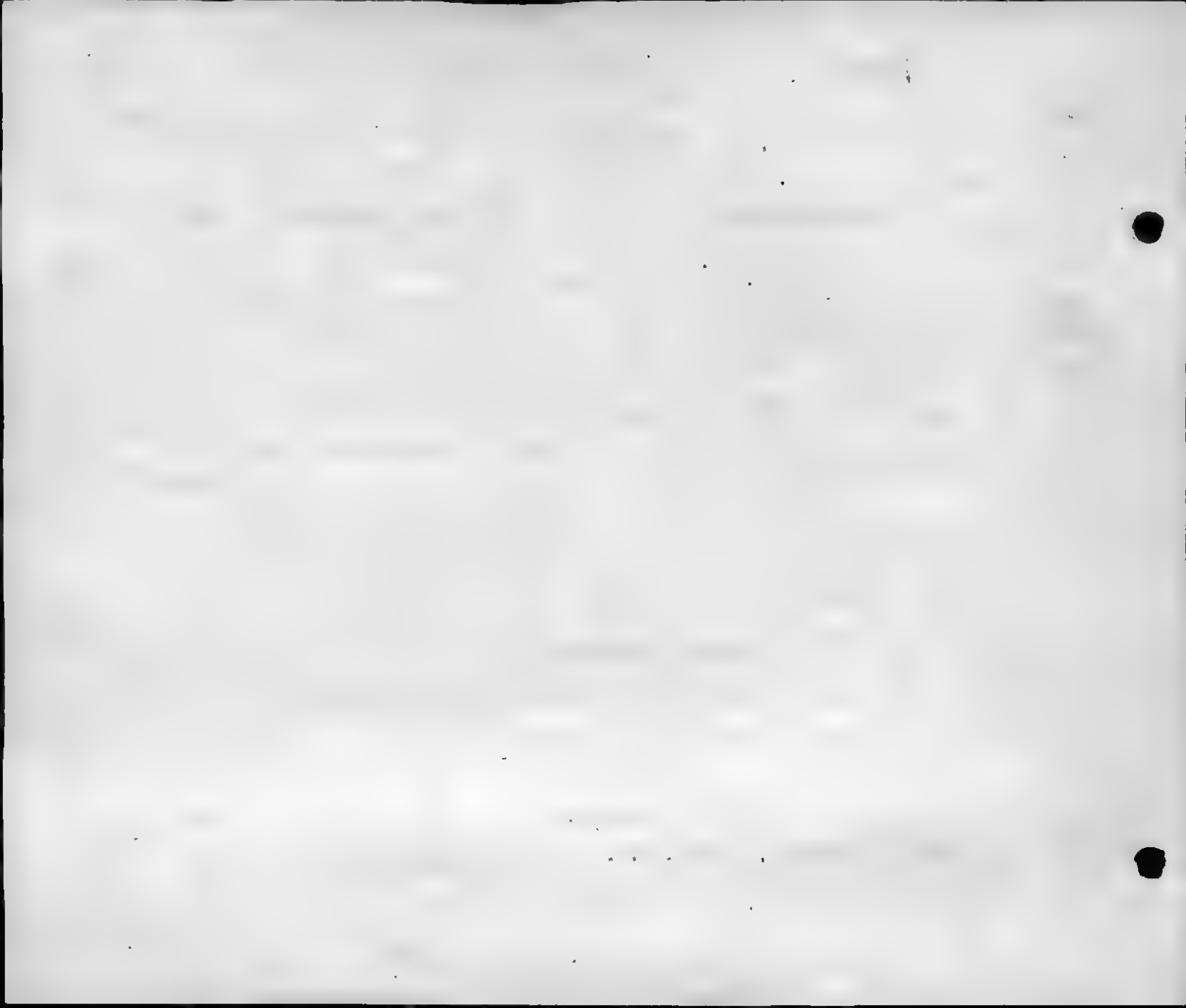
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Russell S. Fisher M.D. CHIEF MEDICAL EXAMINER ☒  
EXAMINER'S NAME (Type) Russell S. Fisher, M.D. ASSISTANT MEDICAL EXAMINER ☐  
DATE SIGNED 7/11/60  
DEPUTY MEDICAL EXAMINER ☐  
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF July 13, 1960 22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery 22d. LOCATION (City, town, or country) (State) Colmar Manor, Md.

23. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md. ADDRESS Ft Lincoln Cemetery 24a. REC'D BY REGISTRAR JUL 15 '60 24b. REGISTRAR'S SIGNATURE Arthur S. K...



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 7795

7812

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland Line</u>		c. LENGTH OF STAY IN 1b <u>2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland Line</u>		d. STREET ADDRESS <u>1 Main St (York Rd.)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Main St. (York Rd.)</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>STIFFLER</u>				4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 24, 1905</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Freeland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George H. Stiffler</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Brennehan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>18409-4715</u>		17. INFORMANT <u>Mrs. Naomi Stiffler, Md. Line Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Strangulation by hanging</u> DUE TO <u>  </u> (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>  </u> DUE TO <u>  </u> (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Hung from a wire attached to a pipe</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>11:35</u> p. m. <u>7:15</u> 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg, etc.) <u>Home</u>		20f. (City or town) <u>Md. Line Baltimore</u>	(County) <u>  </u>	(State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>C. M. France</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7/25/60</u>	
EXAMINER'S NAME (Type) <u>H. M. F. FRANCE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial July 28, 1960</u>		22b. DATE THEREOF <u>July 28, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Elizabeth Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Rock P.R.D.3.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hartenstein, New Freedom, Pa.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. France</u>	

MEDICAL CERTIFICATION

TO DEPARTMENT OF HEALTH: This certificate should be executed within 24 hours after death. If any cause of death is necessary, please execute it in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 4 and 5 with the registrar prior to burial, cremation, or removal.



## CERTIFICATE OF DEATH

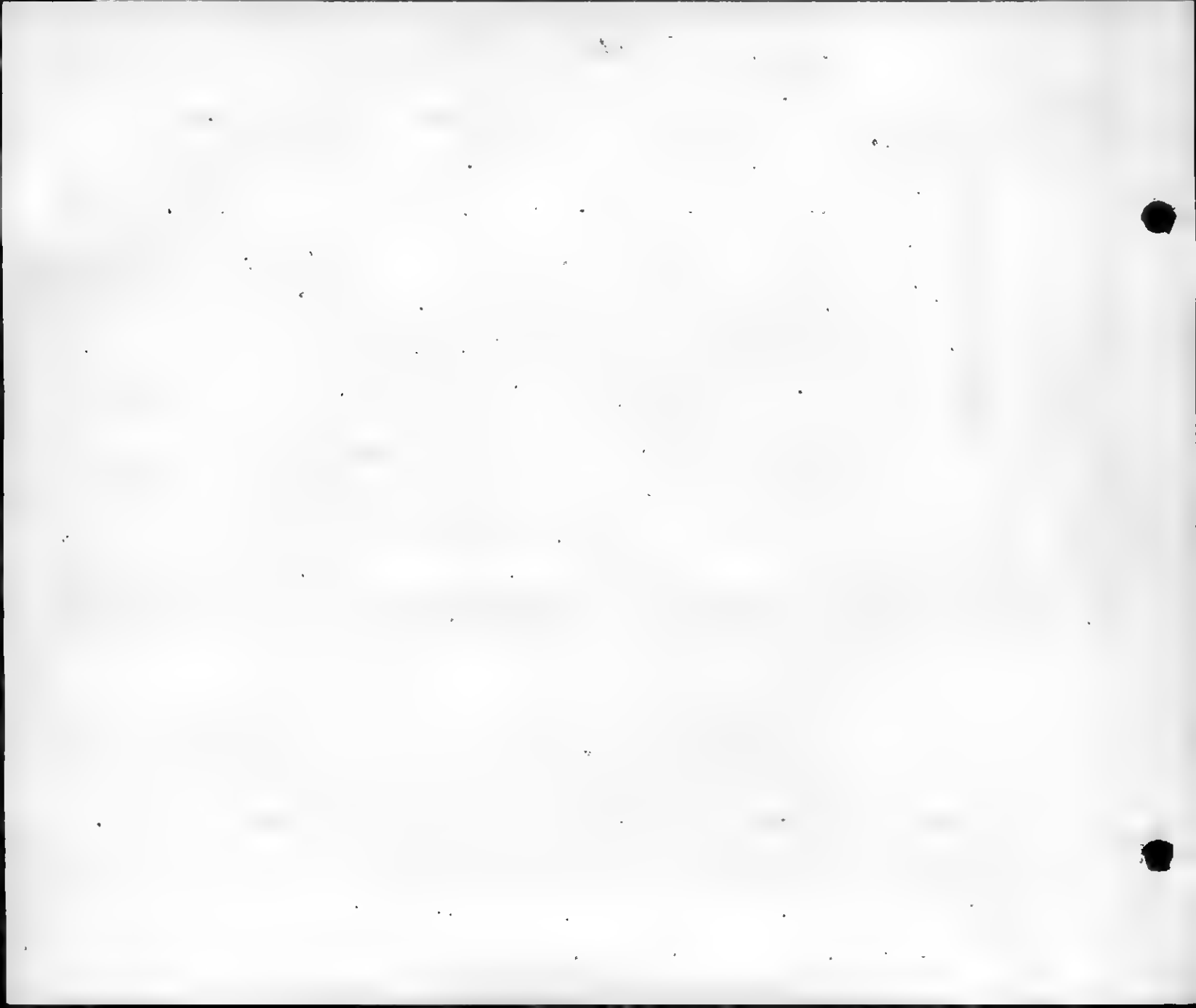
Reg. Dist. No. 07796

7813

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville 4</u>		c. LENGTH OF STAY IN 1b <u>3 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor Aged Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>C Warner Stork</u>		4. DATE OF DEATH <u>July 15 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-26-1867</u>
9. AGE (In years last birthday) <u>93</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Stork</u>		14. MOTHER'S MAIDEN NAME <u>Clintonia Warner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> DUE TO <u>Pulmonary Edema, massive</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Hemorrhage from Bladder</u> DUE TO <u>Arterio Sclerotic Heart Disease</u> DUE TO <u>Arterio Sclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>about 25 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 4</u> , 19 <u>28</u> , to <u>July 15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>July 15</u> , 19 <u>60</u> , and that death occurred at <u>2:30</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore H. Morrison M.D.</u>		ADDRESS (Street, city or town, state) <u>11 E. Chase St.</u>	
PHYSICIAN'S NAME (Type) <u>Theodore H. Morrison</u>		DATE SIGNED <u>7/16/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-18-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson, Inc.</u>		ADDRESS <u>1050 York Road, Towson</u>	
24a. REC'D BY REGISTRAR <u>Jul 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

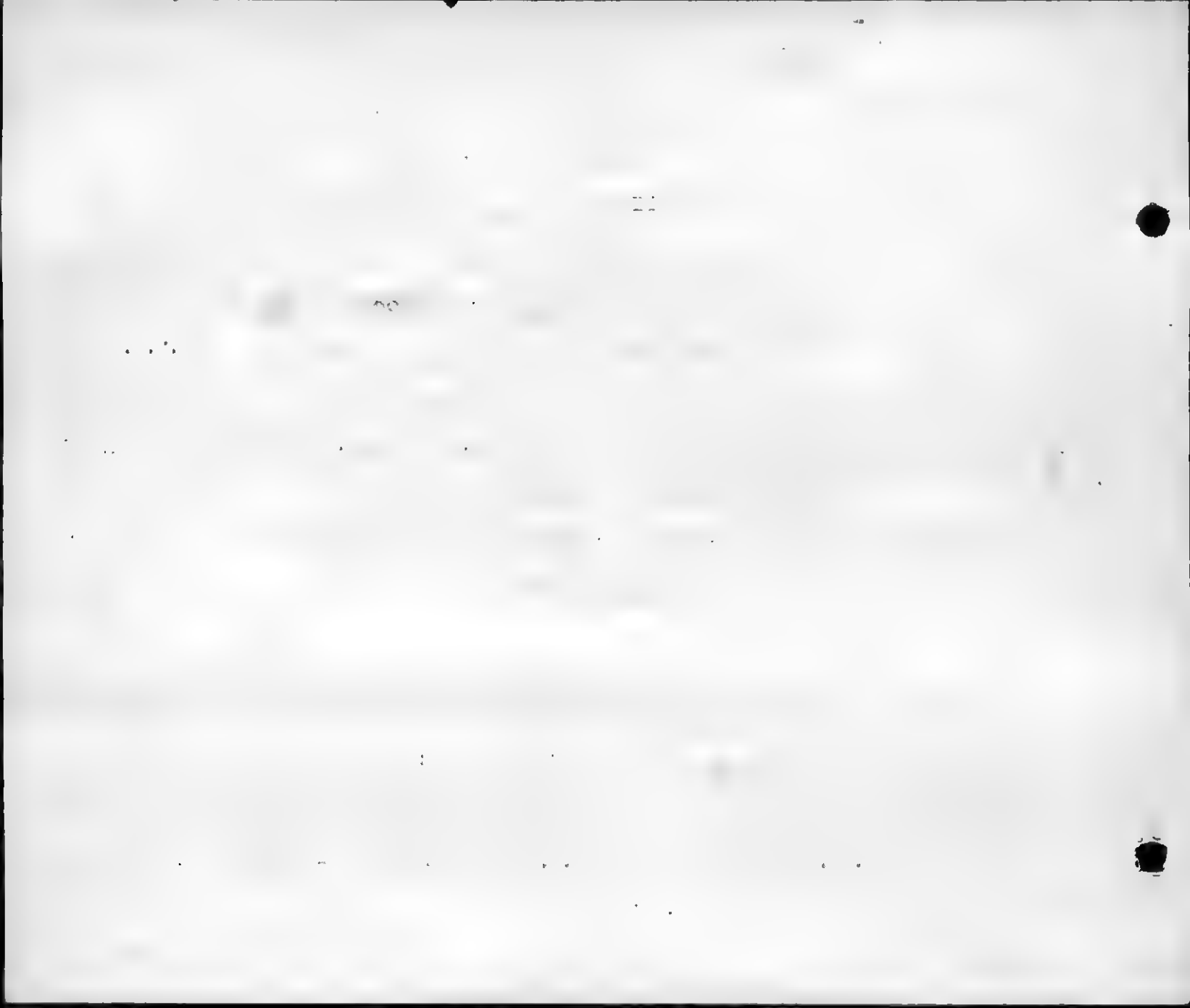
7814

CERTIFICATE OF DEATH

07797

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>11 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
f. STREET ADDRESS <b>113 WELCOME ALLEY</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>R</b> Last <b>STRANGE</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>13</b> Year <b>1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>COLORED</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCTOBER 3, 1889</b>	
9. AGE (In years last birthday) <b>70</b>		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <b>RICHMOND VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>			
13. FATHER'S NAME <b>THOMAS STRANGE</b>				14. MOTHER'S MAIDEN NAME <b>MAGGIE CLARK</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>212 09 3901</b>			
17. INFORMANT <b>CLIN REC. VAH BALTO 18, MD FT HOWARD DIVISION</b>				Address			
18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RENAL INSUFFICIENCY</b>							
DUE TO (b) <b>CARCINOMA OF PROSTATE WITH REMOTE METASTASES</b>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CEREBRAL ARTERIOSCLEROSIS</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>BALTIMORE</b>				20g. (County) <b>MARYLAND</b>		20h. (State) <b>MARYLAND</b>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JULY 2</b> 1960 to <b>JULY 13</b> 1960 that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>JULY 13</b> 1960 and that death occurred at <b>11:20 P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>C. B. COPE</b>				22b. DATE SIGNED <b>7-13-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>C. B. COPE</b>				22d. ADDRESS <b>M.D. VAH BALTO 18 MD - FT HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7/18/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ISAIAH L BROWN &amp; SON BALTIMORE MARYLAND</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 19 '60</b>		25b. REGISTRAR'S SIGNATURE <b>William L. Thomas</b>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

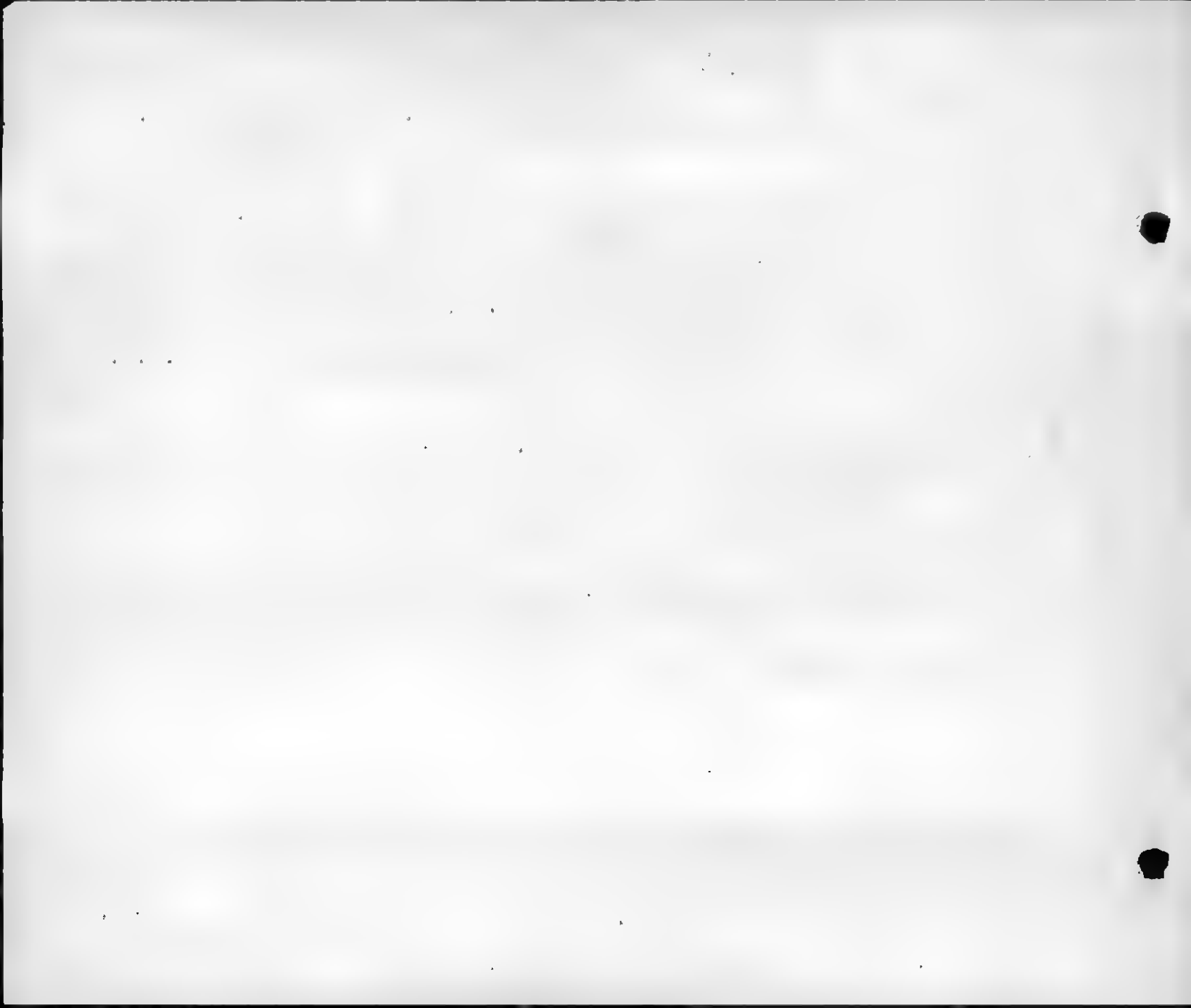
7815

## CERTIFICATE OF DEATH

Reg. Dist. No. 27798

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>Woodlawn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Forest Haven Nursing Home</b>		d. STREET ADDRESS <b>6734 Windsor Mill Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Dora Sutch</b>		4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 10, 1868</b>
9. AGE (In years last birthday) <b>91</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Clingman</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Mrs. Irene Bartell</b>		Address <b>6734 Windsor Mill Rd</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIO-SCLEROTIC CEREBRAL VASCULAR DISEASE</b> DUE TO (c) <b>PULMONARY EMPHYSEMA</b> DUE TO (c) <b>SENILITY</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/5</b> 1960, to <b>7/5</b> 1960, that I last saw the deceased alive on <b>7/5</b> 1960, and that death occurred at <b>M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>John T. Stansbury</b> M.D. <b>SSW Edith Bartell</b> 7/6/60 PHYSICIAN'S NAME (Type) <b>Dora Sutch</b> <b>Barto</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 8, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive</b>		22d. LOCATION (City, town, or county) (State) <b>Randallstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Stansbury</b>		ADDRESS <b>6411 Windsor Mill Rd.</b>	
24a. REC'D BY REGISTRAR <b>JUL 7 '60</b>		24b. REGISTRAR'S SIGNATURE <b>C. H. S. K...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(3)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7816

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02799

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Freeland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Freeland</u>	
c. LENGTH OF STAY IN TB <u>2 hrs</u>		d. STREET ADDRESS <u>Valley Mill Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Morris Rd</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Helvin Eugene Swan</u>		4. DATE OF DEATH Month Day Year <u>July 24 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 25 1951</u>
9. AGE (in years last birthday) <u>8</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>York, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Curtis E. Swan</u>		14. MOTHER'S MAIDEN NAME <u>June A. Young</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Curtis C. Swan</u>		Address <u>Freeland Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (c), stating the underlying cause lost. DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Drowned while bathing in a pond</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>3 7/24 1960</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Freeland</u>		20f. (City or town) (County) (State) <u>Freeland Baltimore Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Chas. F. France</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial July 26 1960</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Freeland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u>		ADDRESS <u>New Freedom</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>JUL 27 '60</u>			



1

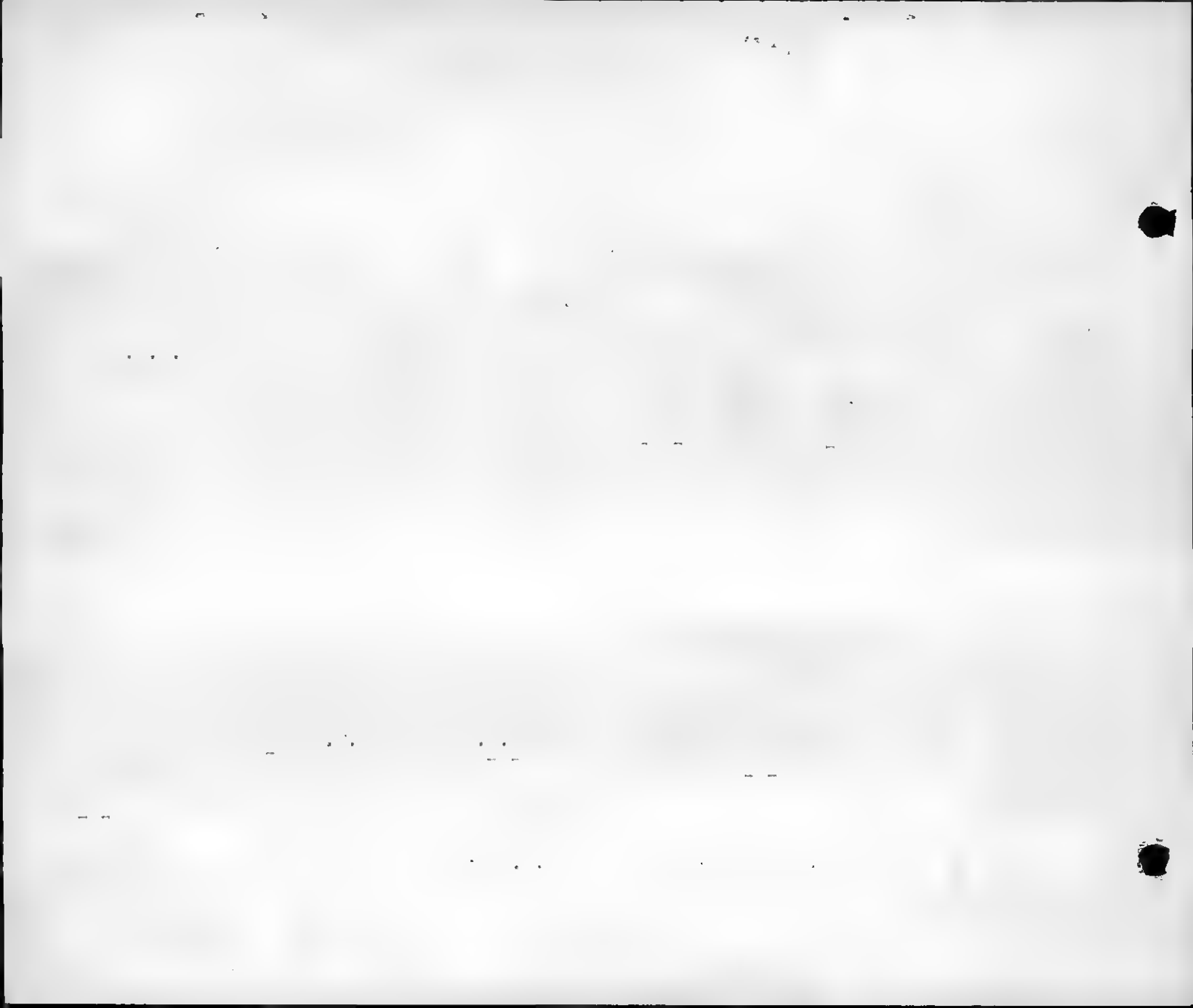
MARYLAND STATE DEPARTMENT OF HEALTH

7817 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07800

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>4 HRS 40 MIN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LOYD</b> Middle <b>N</b> Last <b>TABB</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>6</b> Year <b>19 60</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 21 1894</b>
9. AGE (In years last birthday) <b>65</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MANAGER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ADVERTISING</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN P TABB</b>		14. MOTHER'S MAIDEN NAME <b>NELLIE MCKENZIE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>216-20-2905</b>	
17. INFORMANT <b>CLIN REC VAH BALTO MD FT HOWARD DIVISION</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EMPHYSEMA PULMONARY</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>LAENNEC'S CIRRHOSIS</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>BUERGER'S DISEASE, HISTORY OF</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11:00 A.M. to 3:40 P.M.</b> <b>7-6-60</b> to <b>7-6-60</b> 19____, that (I) (we) last saw the deceased alive on <b>7-6-60</b> 19____, and that death occurred at <b>3:40</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>JOHN K. EBLING</b>		22b. DATE SIGNED <b>7-6-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN K. EBLING</b>		22d. ADDRESS <b>M.D. VAH BALTIMORE 18 MD-FT HOWARD DIVISION</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>July 8, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>SHARON CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>MIDDLEBURG VIRGINIA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W Jenkins &amp; Sons Inc</b>		25a. REC'D BY REGISTRAR <b>JUL 8 '60</b>	
ADDRESS <b>4905 York Rd Baltimore Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	



1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7818

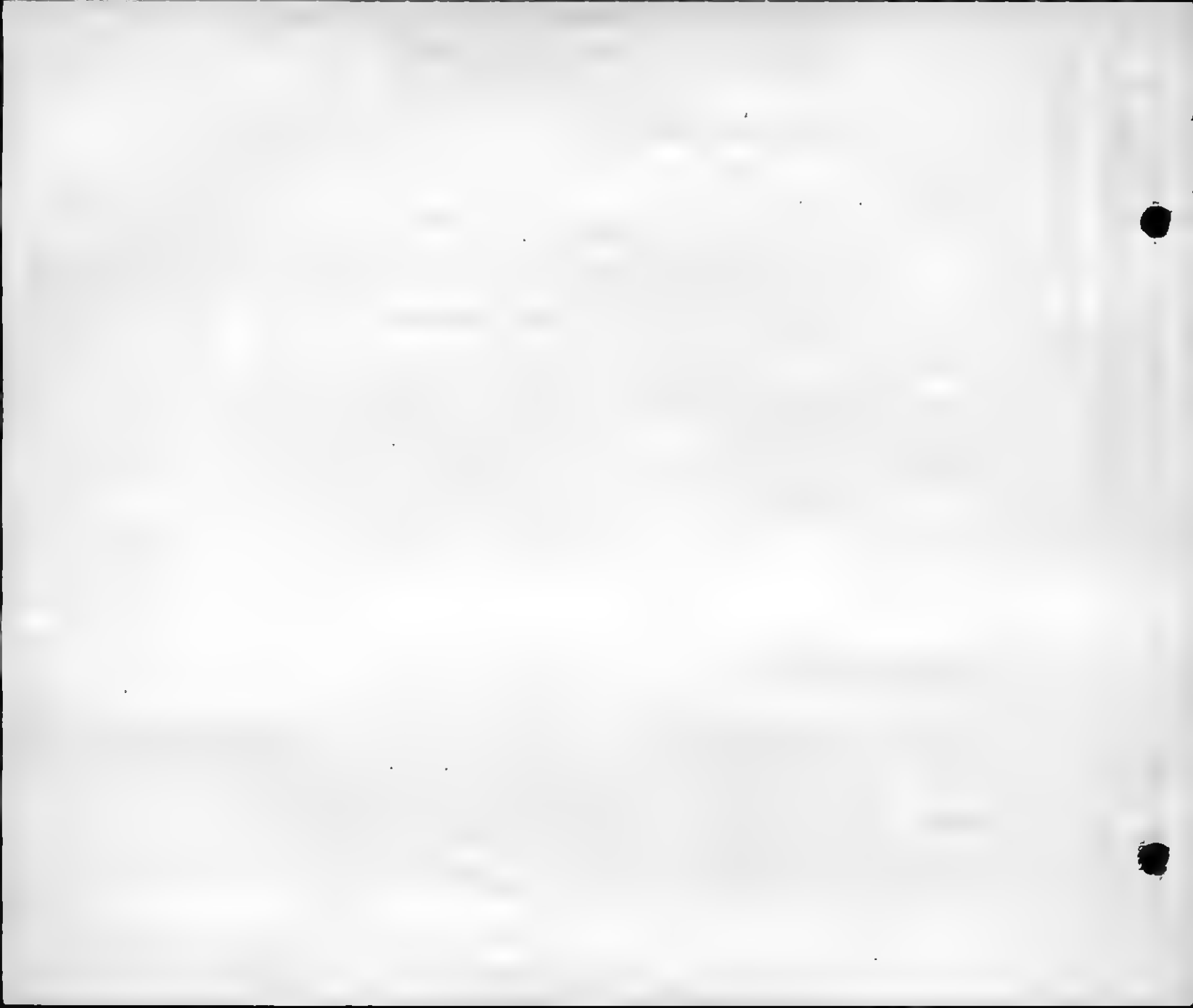
CERTIFICATE OF DEATH

Reg. Dist. No.

07801

1 PLACE OF DEATH a COUNTY <u>Baltimore Co.</u> <sup>#19</sup> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b COUNTY <u>Balto.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgemere</u>		c LENGTH OF STAY IN 1b <u>6 Mo.</u>	
d. NAME OF HOSP TAL (If not in hospital, give street address) OR INSTITUTION <u>254 Oak Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Taylor</u> Last <u>Taylor</u>		4 DATE OF DEATH <u>July 6 - 5</u> 19 <u>60</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10-28-05</u>
9 AGE (In years last birthday) <u>54</u> yrs.		10. F UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12b KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
13. FATHER'S NAME <u>George W. Davison</u>		14 MOTHER'S MAIDEN NAME <u>Martha Long</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16 SOCIAL SECURITY NO. <u>#19</u>	
17. INFORMANT <u>Marion Hopkins, 254 Oak Ave.</u>		Address <u>#19</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>IX</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>7 yrs. ago.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 27, 1960</u> to <u>July 5, 1960</u> that I last saw the deceased alive on <u>July 5, 1960</u> and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis N. Tollin</u> M.D.		ADDRESS (Street, city or town, state) <u>6908 N. Point Rd.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Louis N. Tollin M.D.</u>		<u>BALTO-19-Md</u>	
22a BURIAL, CREMATION, REMOVAL (Specify)	22b DATE THEREOF <u>7-8-60</u>	22c NAME OF CEMETERY OR CREMATORY <u>Mt Calvary</u>	22d LOCATION (City, town, or county) (State) <u>A. A. Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u> ADDRESS <u>802 Mad. Ave</u>		24a REC'D BY REGISTRAR <u>DATE JUL 7 '60</u> 24b REGISTRAR'S SIGNATURE <u>Chas. R. Law</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7819

## CERTIFICATE OF DEATH

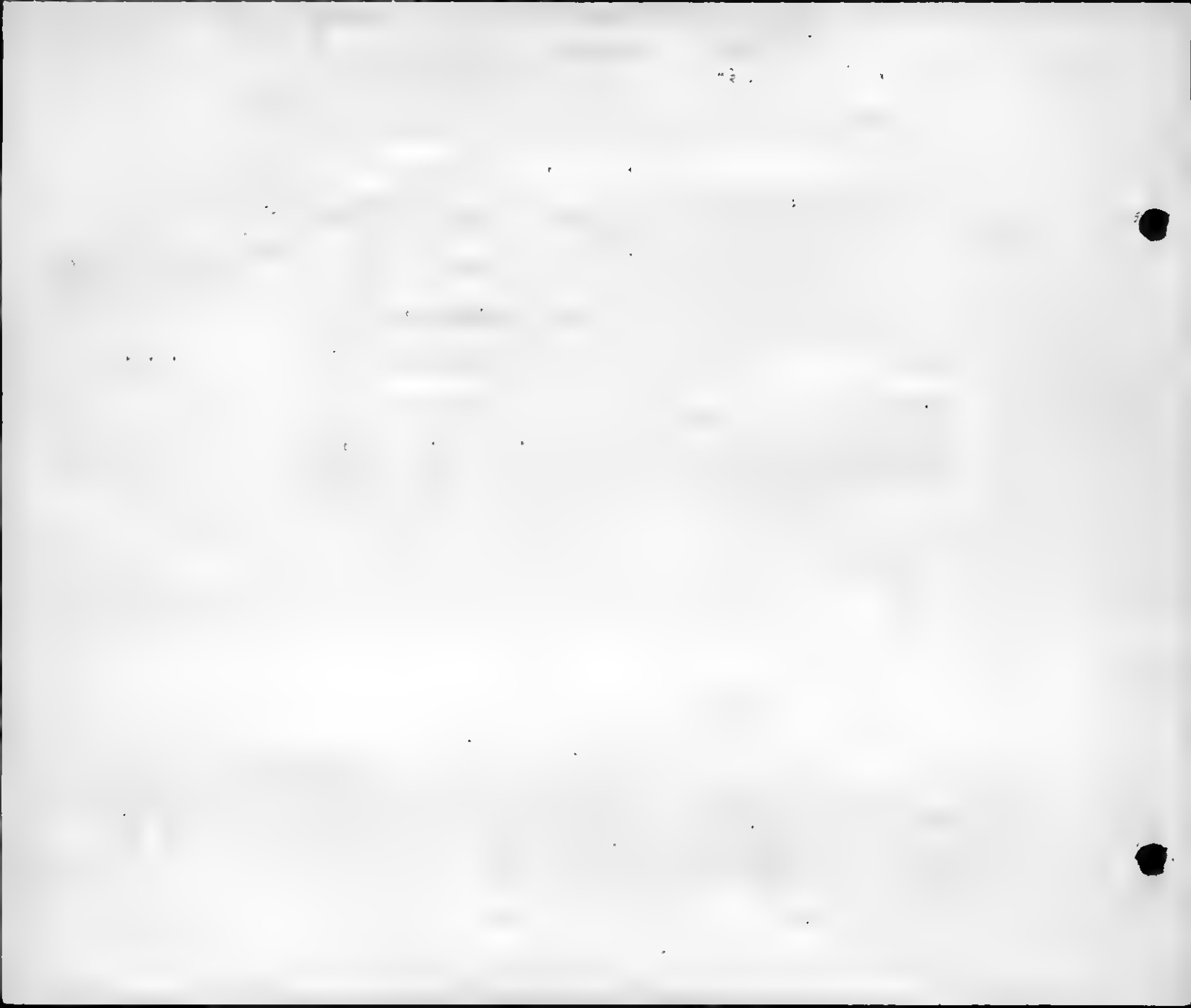
Reg. Dist. No.

07802

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stella Maris Hospice</b>		d. STREET ADDRESS <b>510 Cathedral Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Julia</b> Middle <b>Caroline</b> Last <b>Thomas</b>		4. DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 19, 1875</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 1 MRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Governess</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>West Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Carl Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Thomas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>none</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Elsa T. Becker, 725 Colorado Avenue, Zone 10</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Arteriosclerotic Coronary</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Renal / vascular</b> DUE TO (c) <b>Renal / vascular</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>6-year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 1955</b> to <b>July 3, 1960</b> that I last saw the deceased alive on <b>July 3, 1960</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>7501 York Rd Baltimore, Md.</b> DATE SIGNED <b>7/3/60</b>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.		PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell #4 771d</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-6-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>5839 Ritchie Highway, Zone 25</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 6 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7820

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

078113

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 447</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u> d. STREET ADDRESS <u>Box 447</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>W.</u> Last <u>Thurfield</u>		4. DATE OF DEATH Month <u>7</u> Day <u>31</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-18-1896</u> 1895 <u>64</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Edgewood Ars.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert Thurfield</u>		14. MOTHER'S MAIDEN NAME <u>Belle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>1918-1919</u>		16. SOCIAL SECURITY NO. <u>212263536</u>	
17. INFORMANT <u>anna</u> Address <u>Mrs Mary J. Thurfield</u>		18. INTERVAL BETWEEN FORESET AND DEATH <u>same</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shot Gun Wound - Left Chest.</u> DUE TO <u>over Heart.</u> Conditions, if any, which gave rise to immediate cause (b) <u>over Heart.</u> (c), stating the underlying cause lost, DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot Self in Heart Region @ 12 Gauge Gun</u>	
20c. TIME OF INJURY Hour <u>2:15</u> p. m. <u>7-31</u> 19 <u>60</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>White Marsh - Baltimore Md.</u> (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M.B. Davis MD</u>		DATE SIGNED <u>8/1/60</u>	
EXAMINER'S NAME (Type) <u>M.B. Davis MD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>8-3-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR <u>AUG 3 '60</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO DET. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7821

## CERTIFICATE OF DEATH

Reg. Dist. No. 07804

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>173 Dumbarton Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Paul G. Tolson</u>		4. DATE OF DEATH Month Day Year <u>July 26 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 7-1911</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assoc. Sec. of Mich.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mar. Land</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert G. Tolson</u>		14. MOTHER'S MAIDEN NAME <u>Edith Wieland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Informant</u>	
17. ADDRESS <u>Mrs. Cecilia A. Tolson 173 Dumbarton Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Transverse Colon</u> DUE TO (b) <u>Metastases to Liver &amp; Spleen</u> DUE TO (c) <u>lymph cause last.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 15, 1959</u> to <u>July 26, 1960</u> , that I last saw the deceased alive on <u>July 24, 1960</u> , and that death occurred at <u>7:35 PM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>John A. Tynes</u> M.D. <u>104 E. Biddle St. Baltimore 2, Md.</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>7/28/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Luck 1205 Harford Road #11</u>		24a. REC'D BY REGISTRAR <u>JUL 28 '60</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7822

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07805

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Balto</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Middle River</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Middle River</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>1808 Wilson Pt. Rd.</i>				d. STREET ADDRESS <i>1808 Wilson Pt. Rd.</i>			
3. NAME OF DECEASED (Type or print) <i>JAMES E. TROTTER</i>				4. DATE OF DEATH <i>July 8 - 1960</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 25-1904</i>	9. AGE (In years last birthday) <i>55</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Planning Man</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Wash D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Milo H. Trotter</i>				14. MOTHER'S MAIDEN NAME <i>May E. Hanley</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>578-05-7896</i>		17. INFORMANT <i>Wife</i> Address <i>Same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary</i> DUE TO (b) <i>Art. Scler. Heart D.s</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <i></i>						INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL <i>Jack E. Collins</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>JACK E COLLINS</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 11-1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Balto Co. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Connolly</i>				24a. REC'D BY REGISTRAR <i>JUL 12 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur D. Hirsch</i>	

TO DEATH MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any is necessary, please examine the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. After pages 1 and 2 with the registrar prior to burial, cremation, or removal



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07806

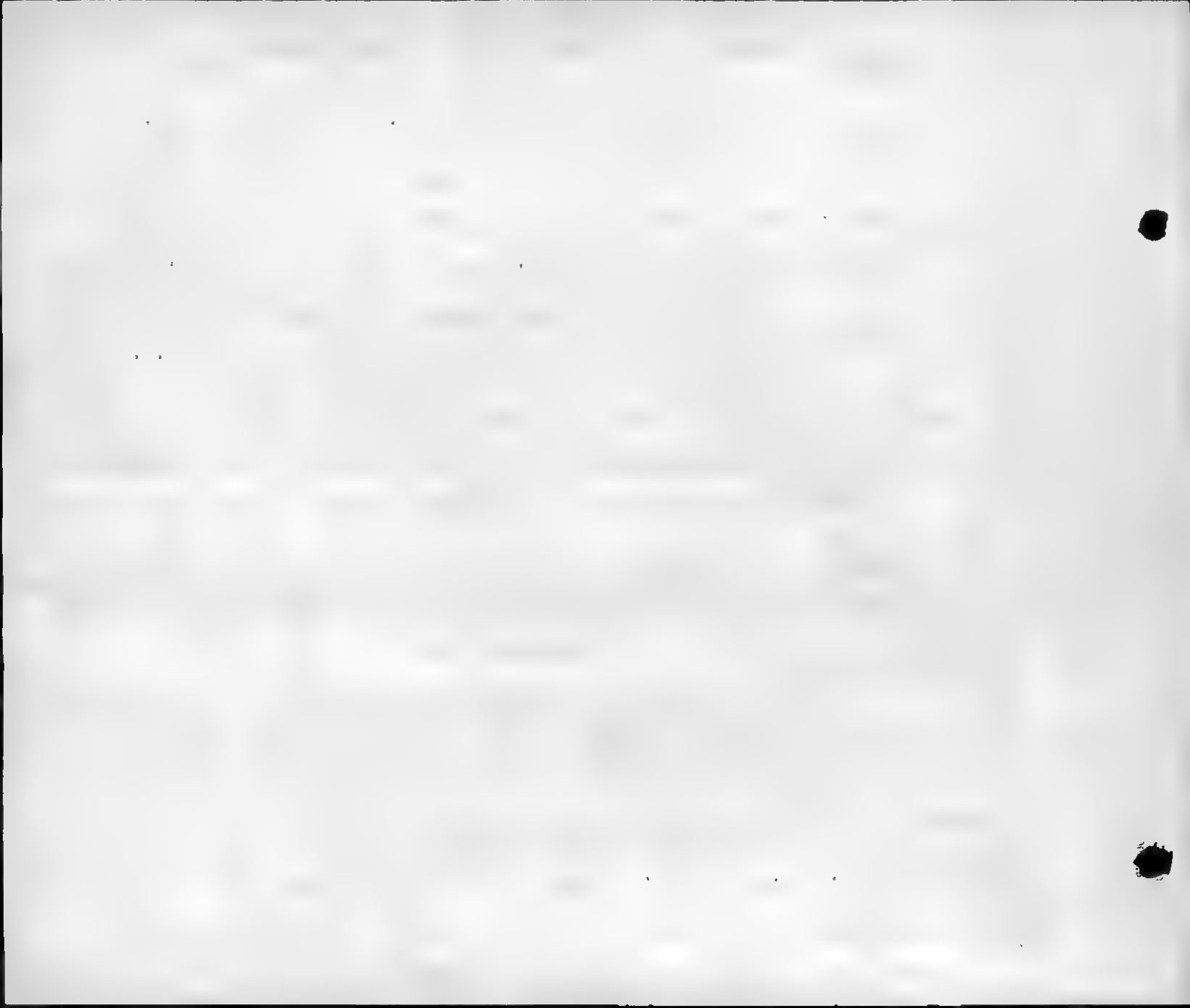
Reg. Dist. No.

7685

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5713 2nd Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Joseph A. Uhlhorn Jr.</u>				4. DATE OF DEATH <u>July 17, 1960</u> 19			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 7, 1902</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brook</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph A. Uhlhorn</u>				14. MOTHER'S MAIDEN NAME <u>Don't know</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>W.W.S.</u>		17. INFORMANT <u>Joseph A. Uhlhorn</u> Address <u>2000 ...</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>George S. M. Kieffer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>JUL 22 '60</u>		<u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If any certificate is necessary, please enclose it with this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7823

## CERTIFICATE OF DEATH

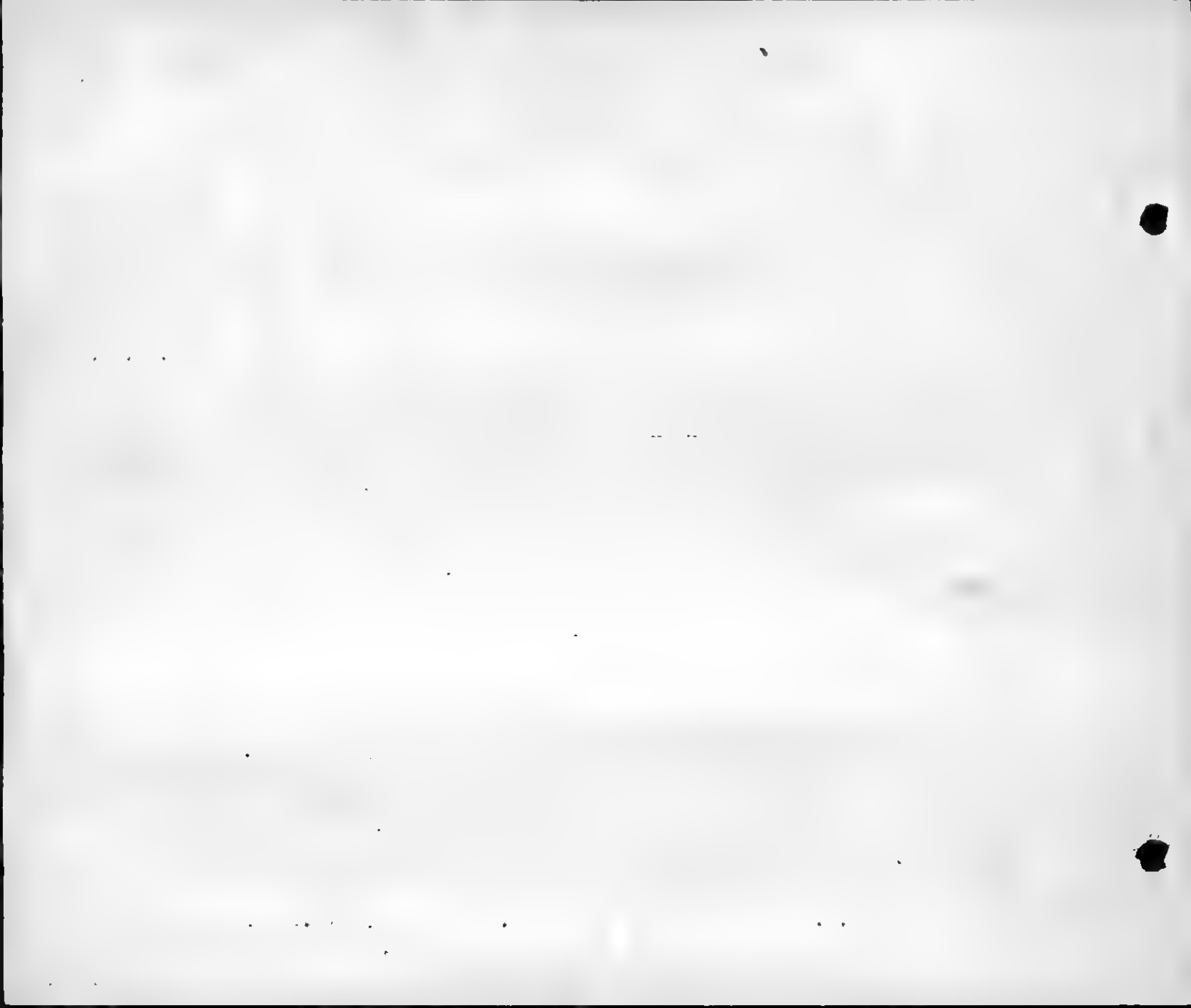
07867

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>19 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>4722 Dunkirk Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Wladyslaw</b> Middle <b>Victor</b> Last		4. DATE OF DEATH Month <b>7</b> Day <b>3</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 27, 1873</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>214-18-2803</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic Cardiovascular Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Arteriosclerosis</b> DUE TO (c) <b>Chronic Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Arteriosclerosis</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 8, 1960</b> to <b>7/3, 1960</b> , that I last saw the deceased alive on <b>7/3, 1960</b> , and that death occurred at <b>10:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>BRAND RADANSKY</b> M.D. <b>SPRING GROVE STATE HOSPITAL</b> <b>7/3/60</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>BRAND RADANSKY</b> <b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7.7.60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Schenck &amp; Son - Balto.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 5 1960</b>	
24b. REGISTRAR'S SIGNATURE <b>J. H. Hume</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

7824

07808

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>2 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>House-In-The-Pines</b>				e. STREET ADDRESS <b>7 Dogwood Road</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>E. Wahaus</b> Last				4. DATE OF DEATH Month <b>7</b> Day <b>17</b> Year <b>1960</b>			
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-23-1869</b>		9. AGE (In years last birthday) <b>90</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min <b>11</b>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George Gettings</b>				14. MOTHER'S MAIDEN NAME <b>Anna D. Yeadaker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <b>Miss Margaret Wahaus Dogwood Rd; Woodlawn, Md</b>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>24 hr</b> <b>1532 (P)</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b>							
19. WAS A JPTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Falling at her home</b>			
20c. TIME OF INJURY Hour <b>3:30</b> p. m. Month <b>5</b> Day <b>16</b> Year <b>1960</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Baltimore, Balt. Co., Md.</b>				20g. (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from <b>7-10-1960</b> to <b>7-17-1960</b> , that (I) (we) last saw the deceased alive on <b>7-16-1960</b> , and that death occurred at <b>7:15 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Walter K. Golliger</b>				22b. DATE SIGNED <b>7-17-60</b>		22c. PHYSICIAN'S NAME (Type) <b>Walter K. Golliger, M.D.</b>	
22d. ADDRESS <b>1207 Frederick Ave, Balt-28, Md.</b>							
23a. BURIAL, CREMATION, REBURYAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-20-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Co. Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Thos. R. H. + Son - 301 N. ...</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 21 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

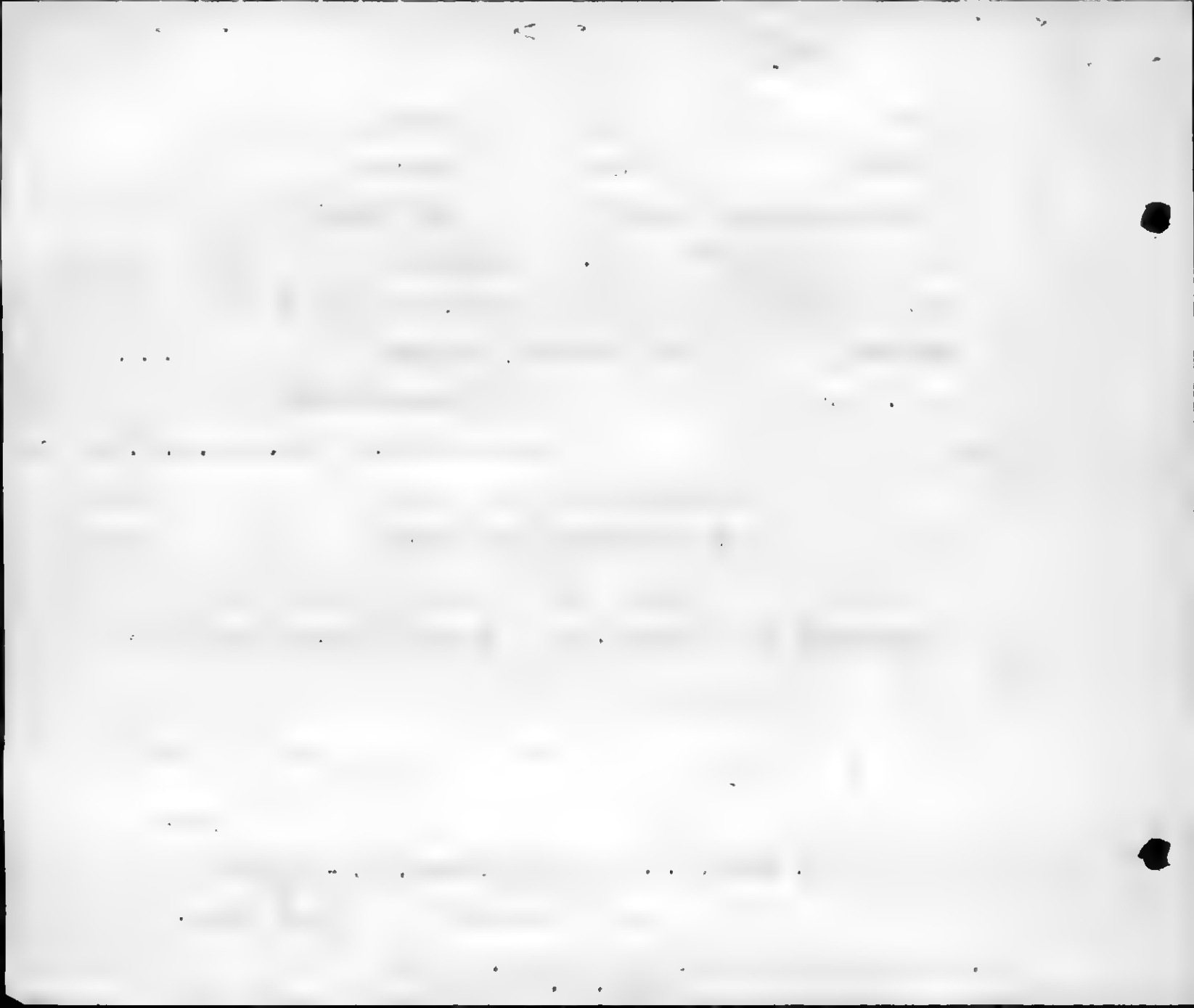


TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 may be signed by the hospital or attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
7825  
CERTIFICATE OF DEATH  
07809

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FT HOWARD</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>3515 Oakmont Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>BENJAMIN C. WALKER</b>		4. DATE OF DEATH Month Day Year <b>JULY 31 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 6, 1872</b>
9. AGE (in years last birthday) <b>88</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Store (Department) Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry C. Walker</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Doughty</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>SPA AMERICAN</b>		16. SOCIAL SECURITY NO. <b>Clin Records, Vet. Adm. Hosp. Balto., Md. Ft. Howard Div</b>	
17. INFORMANT <b>Clin Records, Vet. Adm. Hosp. Balto., Md. Ft. Howard Div</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>UNKNOWN</b> INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DUODENAL ULCER WITH HEMORRHAGE. INTESTINAL OBSTRUCTION, PARTIAL CAUSE UNKNOWN</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 29</b> 19 <b>60</b> to <b>July 31</b> 19 <b>60</b> . that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 31</b> 19 <b>60</b> and that death occurred at <b>10:40 AM</b> on the causes and on the date stated above			
22a. SIGNATURE <b>John K. Ebling</b> 22c. PHYSICIAN'S NAME (Type) <b>JOHN K. EBELING, M.D.</b>		22b. DATE SIGNED <b>7/31/60</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8-4-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ed. Cook Blight Funeral Home, 6009 Harford Rd. Balto., Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 3 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. House</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

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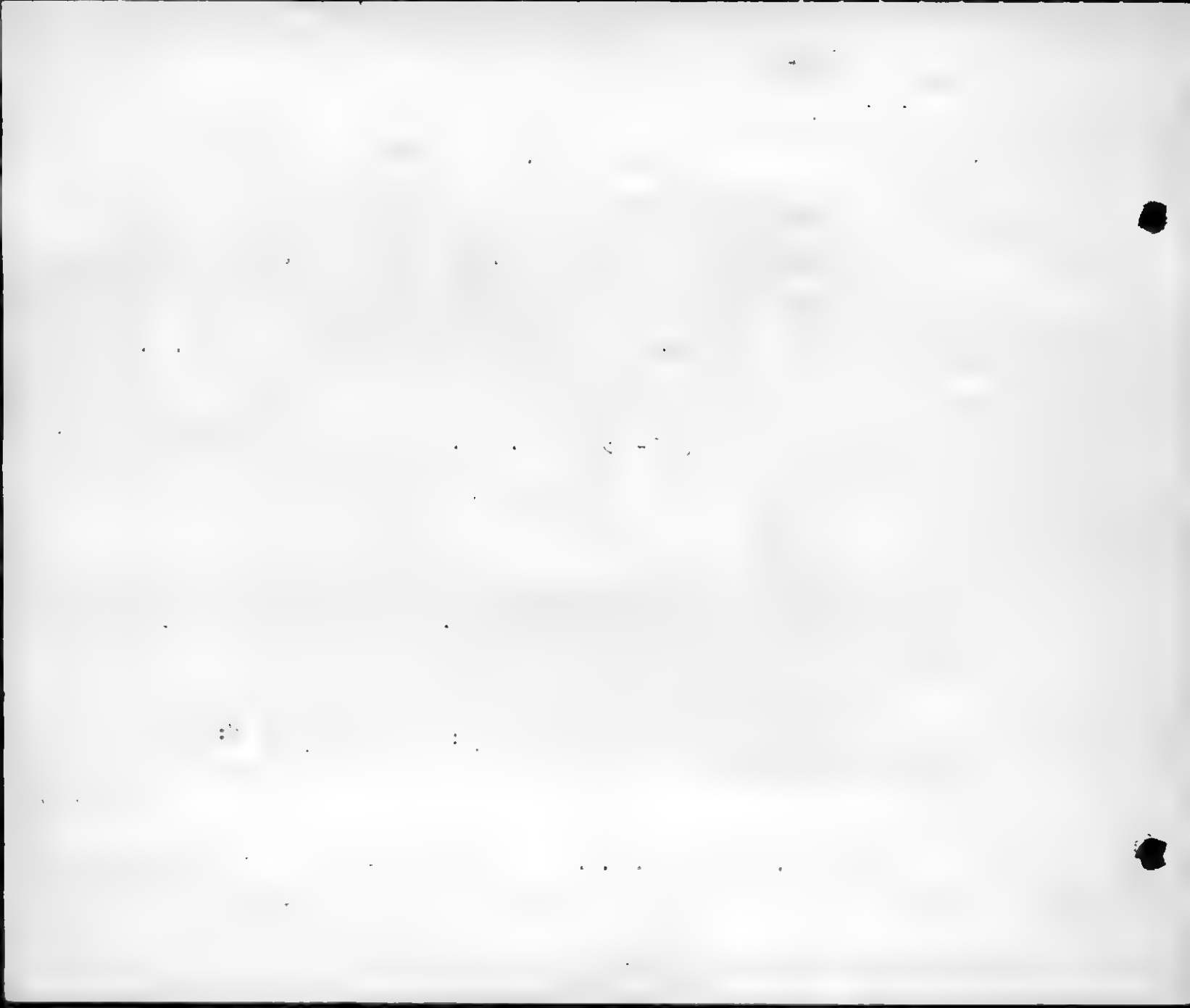
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7826

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07810

1 PLACE OF DEATH a COUNTY <b>BALTIMORE</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE <b>MARYLAND</b> b COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>7 Hours 20 Min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				d STREET ADDRESS <b>2304 Wichita Ave</b>			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE E WARD</b>				4. DATE OF DEATH Month Day Year <b>July 18 1960</b>			
5 SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>April 9 1890</b>	
9. AGE (In years lost birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk</b>				10b KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Arlington, Virginia</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>							
13 FATHER'S NAME <b>James Ward</b>				14 MOTHER'S MAIDEN NAME <b>Florence Gray</b>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>				16. SOCIAL SECURITY NO. <b>217-01-7152</b>		17. INFORMANT <b>Clin. Rec., VAH Balto 18, Md Ft Howard Division</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a) and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA LEFT LOWER LOBE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <b>Lymphoma, abdominal &amp; thoracic; Left ventricular hypertrophy &amp; dilatation</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b>							
19 WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month Day Year Hour o m. p m. 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street office bldg., etc.)	
20f (City or town) <b>July 18, 1:00PM '60</b>				20g (County) (State) <b>July 18, 8:20PM '60</b>			
21 I certify that (X) (this hospital) attended the deceased from <b>July 18, 1960</b> to <b>July 18, 1960</b> that (X) (we) last saw the deceased alive on <b>July 18, 1960</b> , and that death occurred at _____ M, from the causes and on the date stated above							
22a SIGNATURE <i>Walter J. Pijanowski</i>				22b DATE <b>7/19/60</b>			
22c PHYSICIAN'S NAME (Type) <b>WALTER J. PIJANOWSKI, M.D.</b>				22d ADDRESS <b>VAH BALTO 18, MD FT HOWARD DIVISION</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b DATE THEREOF <b>7-22-60</b>		23c NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	
23d LOCATION (City, town, or county) <b>Baltimore, Maryland</b>				(State)			
24 FUNERAL DIRECTOR'S SIGNATURE <i>John M. Johnson</i>				ADDRESS <b>1011 Arlington Ave Balto Md</b>		25a REC'D BY REGISTRAR <b>JUL 22 '60</b>	
25b REGISTRAR'S SIGNATURE <i>Arthur S. House</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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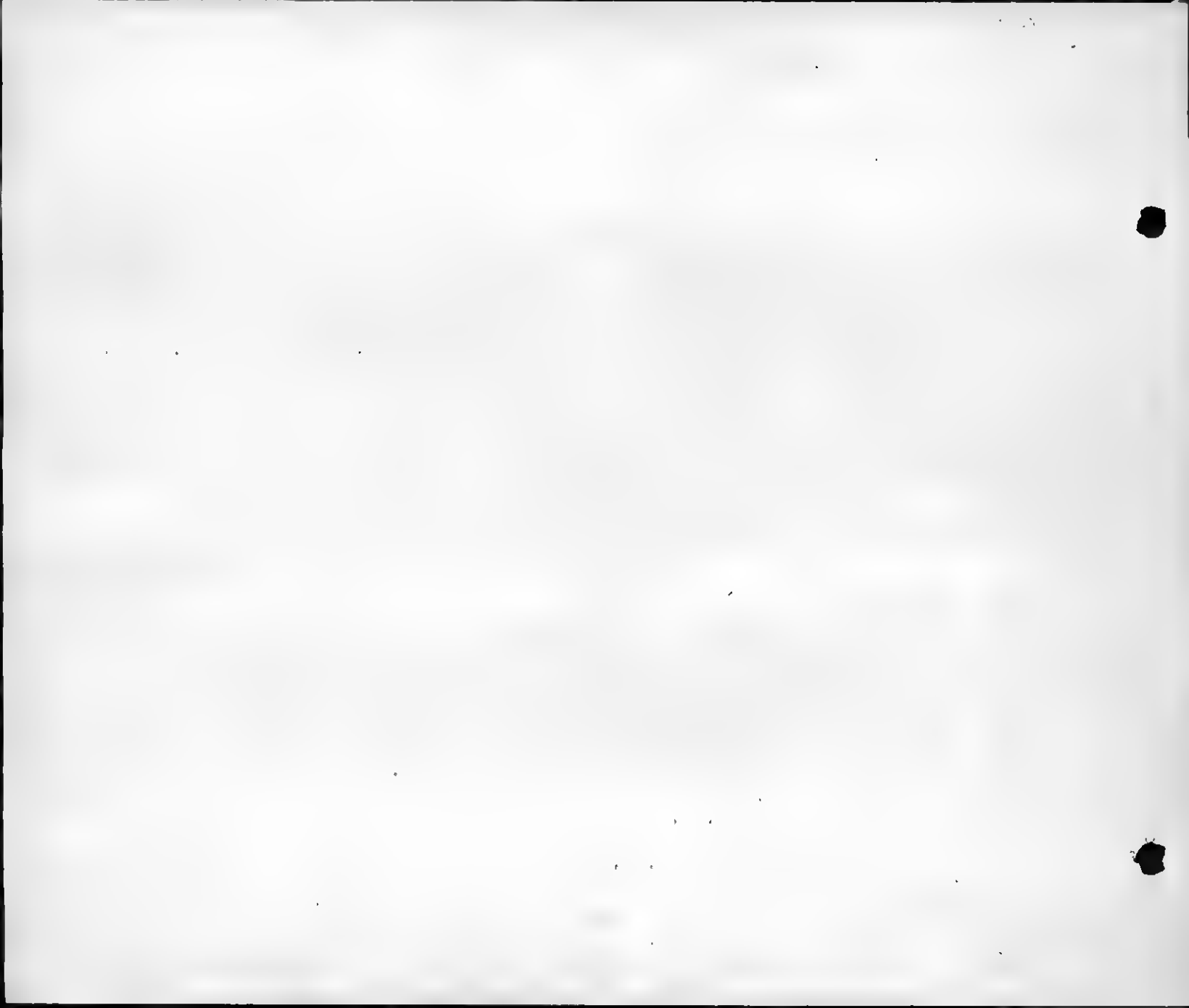
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7827

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

07811

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN lb <b>1mth16dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>Warfield</b> Last <b>Warfield</b>				4. DATE OF DEATH Month <b>July</b> Day <b>18</b> Year <b>1960</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1874</b>	
9. AGE (In years last birthday) <b>86</b> yrs		10. UNDER 1 YEAR Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min <b>86</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Records; SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gangrenous urinary cystitis</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>BALTIMORE</b>				20g. (County) <b>BALTIMORE</b>		20h. (State) <b>MARYLAND</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>June 2, 1960</b> to <b>July 18, 1960</b> , that (I) (we) last saw the deceased alive on <b>July 18, 1960</b> , and that death occurred at <b>12:20 a.m.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Stella Wachslar, M.D.</b>				22b. DATE SIGNED <b>7-18-60</b>		22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M.D.</b>	
22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 20, Maryland</b>				22e. REC'D BY REGISTRAR <b>Arthur S. Kneiss</b>			
23a. BURIAL CREMATION REMOVAL (Specify) <b>7-21-60</b>				23b. DATE THEREOF <b>7-21-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DRUID RIDGE</b>	
23d. LOCATION (City, town, or county) <b>BALTIMORE</b>				23e. (State) <b>MARYLAND</b>		23f. REGISTRAR'S SIGNATURE <b>Arthur S. Kneiss</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Luck 5305 Harford Rd.</b>							



may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

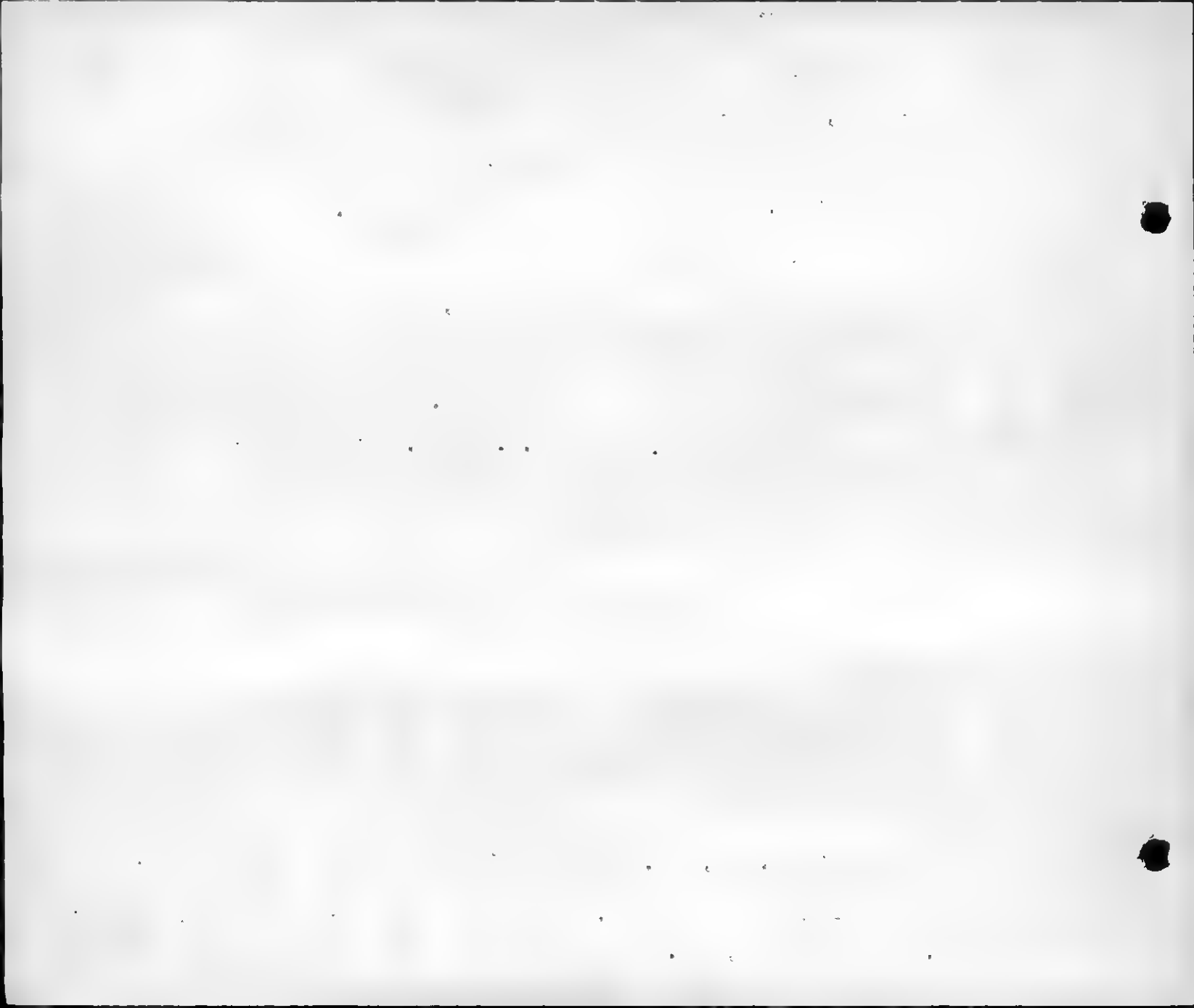
CERTIFICATE OF DEATH

7828

Items 1, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

07812

1. PLACE OF DEATH a. COUNTY <b>Maryland, Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armacost Nursing Home</b>		e. STREET ADDRESS <b>1612 Bolton St.</b>	
3. NAME OF DECEASED (Type or print) <b>Kate Darby Watson</b>		4. DATE OF DEATH Month <b>July</b> Day <b>15</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 11, 1874</b>
9. AGE (In years lost birthday) <b>86</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles Darby</b>		14. MOTHER'S MAIDEN NAME <b>Mary K. McLean</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Mrs. Howard O. Buffington 1338 Crofton Road</b>		CHIEF ASST. MEDICAL EXAMINER <b>M.D.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>H. yperstatic pneumonia</b> DUE TO <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>Concomitant of the arteries, Boleb's sarcoid</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of left hip - 20 APR 60</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>years</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Fell getting out of bed at home</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>21 APR 1960</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Baltimore</b> <b>And</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>25 May 1960</b> to <b>15 Jul 1960</b> , that (I) (we) last saw the deceased alive on <b>15 Jul 1960</b> , and that death occurred at <b>8 PM</b> , from the causes and on the date stated above			
22a. SIGNATURE <b>W. F. Cox</b>		22b. DATE SIGNED <b>16 Jul 60</b>	
22c. PHYSICIAN'S NAME (Type) <b>William F. Cox, 3rd.</b>		22d. ADDRESS <b>1118 St. Paul St. Baltimore 2, And</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-18-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>		23d. LOCATION (City, town, or county) (State) <b>Ellicott City, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons, Inc. 1900 Eutaw Place</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 18 '60</b>	
		25b. REGISTRAR'S SIGNATURE <b>Clifford L. Kenna</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

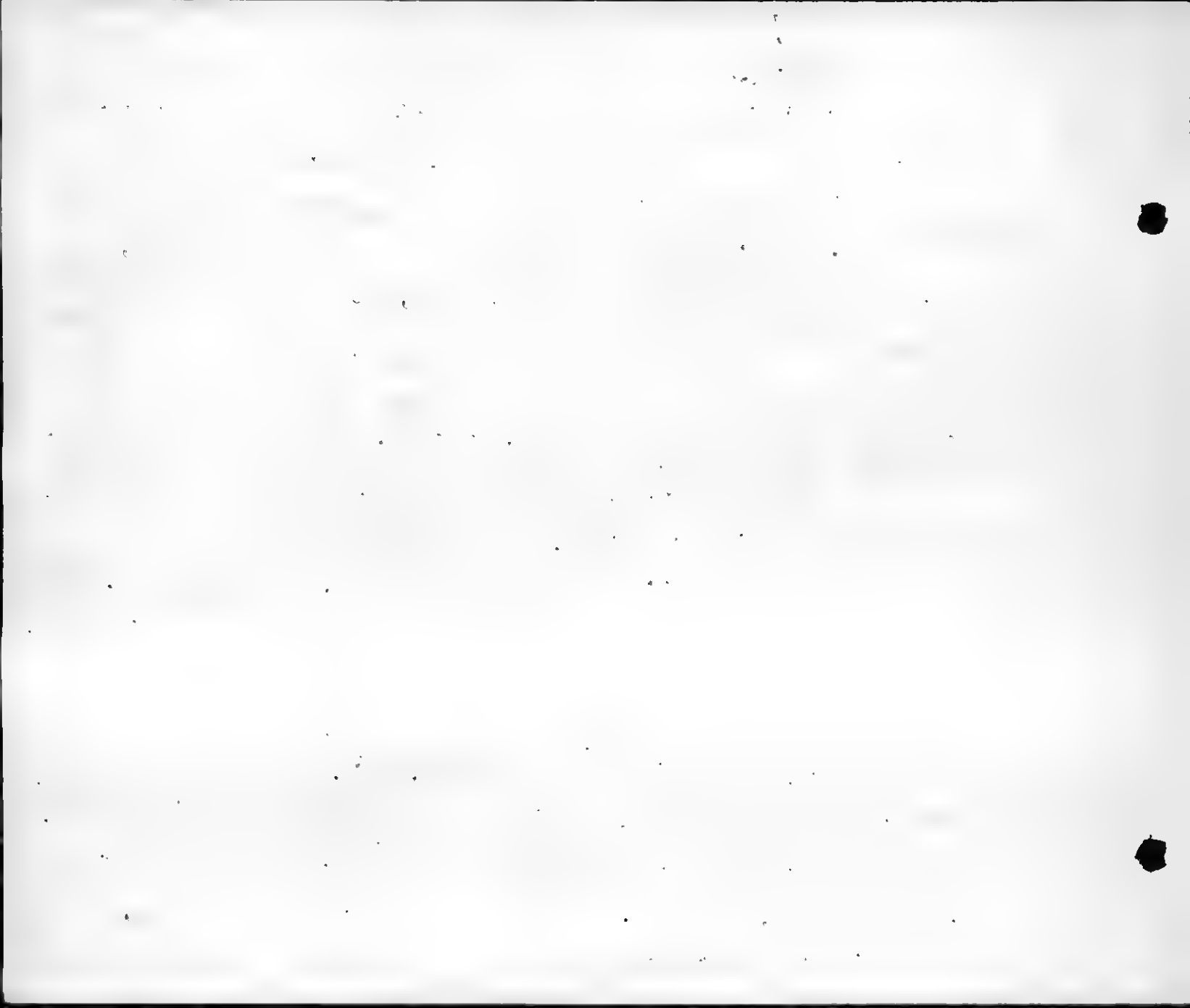
07813

7829

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rodgers Forge</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Rodgers Forge</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>331 Overbrook Road</b>		e. STREET ADDRESS <b>331 Overbrook Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Mrs. Theresa</b> Middle <b>Mary</b> Last <b>Watson</b>		4 DATE OF DEATH Month <b>July</b> Day <b>17</b> Year <b>1960</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 8, 1869</b>
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months <b>91</b> Days <b>17</b> Hours <b>19</b> Min <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>August Weiss</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Osche</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Informant</b>	
17. ADDRESS <b>Mrs. Frances S. Kleiber 331 Overbrook Road</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>Generalized Hypertension</b> DUE TO (c) <b>Cardiovascular Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>10 years</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 19, 56</b> to <b>July 15, 1960</b> , that I last saw the deceased alive on <b>July 15, 1960</b> , and that death occurred at <b>12.20 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2501 York Rd 7/18/60</b> DATE SIGNED <b>Charles F. O'Donnell</b>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>			
PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 21, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Augustine</b>	22d. LOCATION (City, town, or county) (State) <b>Millvale, Pennsylvania</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Burgee Funeral Home</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 19 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		24c. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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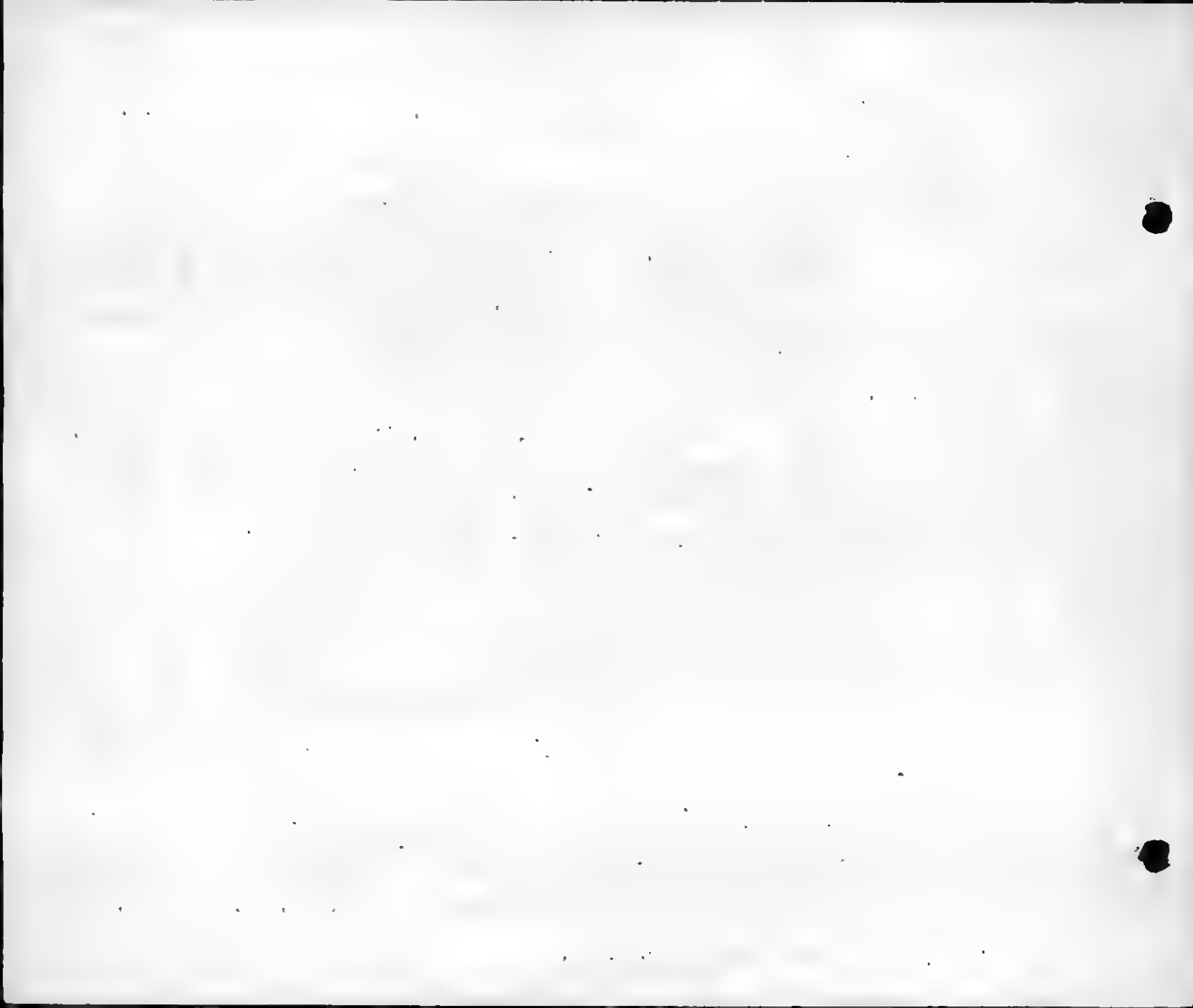
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7690

## CERTIFICATE OF DEATH

Reg. Dist. No. 07814

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Nicodemus Road</b>		e. STREET ADDRESS <b>Nicodemus Road</b> f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>W.</b> Last <b>Wheeler</b>		4. DATE OF DEATH Month <b>July</b> Day <b>16</b> , Year <b>1960</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Oct. 16, 1898</b> 9 AGE (In years last birthday) yrs <b>61</b> IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School bus driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b> 11 BIRTHPLACE (State or foreign country) <b>USA</b> 12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Daniel W. Wheeler</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Peregoy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war, dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-07-5220</b> INFORMANT <b>Mrs. Hilda D. Wheeler</b> Address <b>Reisterstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> <b>163 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>backache</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 yrs</b> INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour o m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-1-30</b> 19 <b>30</b> , to <b>7-16-60</b> , 19 <b>60</b> that I last saw the deceased alive on <b>7-16-60</b> , 19 <b>60</b> and that death occurred at <b>145</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>James G. Saffell</b> M.D. ADDRESS (Street, city or town, state) <b>Reisterstown Md</b> DATE SIGNED <b>7-16-60</b> PHYSICIAN'S NAME (Type) <b>James G. Saffell</b> <b>Reisterstown Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 19, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Forest Baptist Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Eline &amp; Sons</b> ADDRESS <b>Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Jul 19 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>



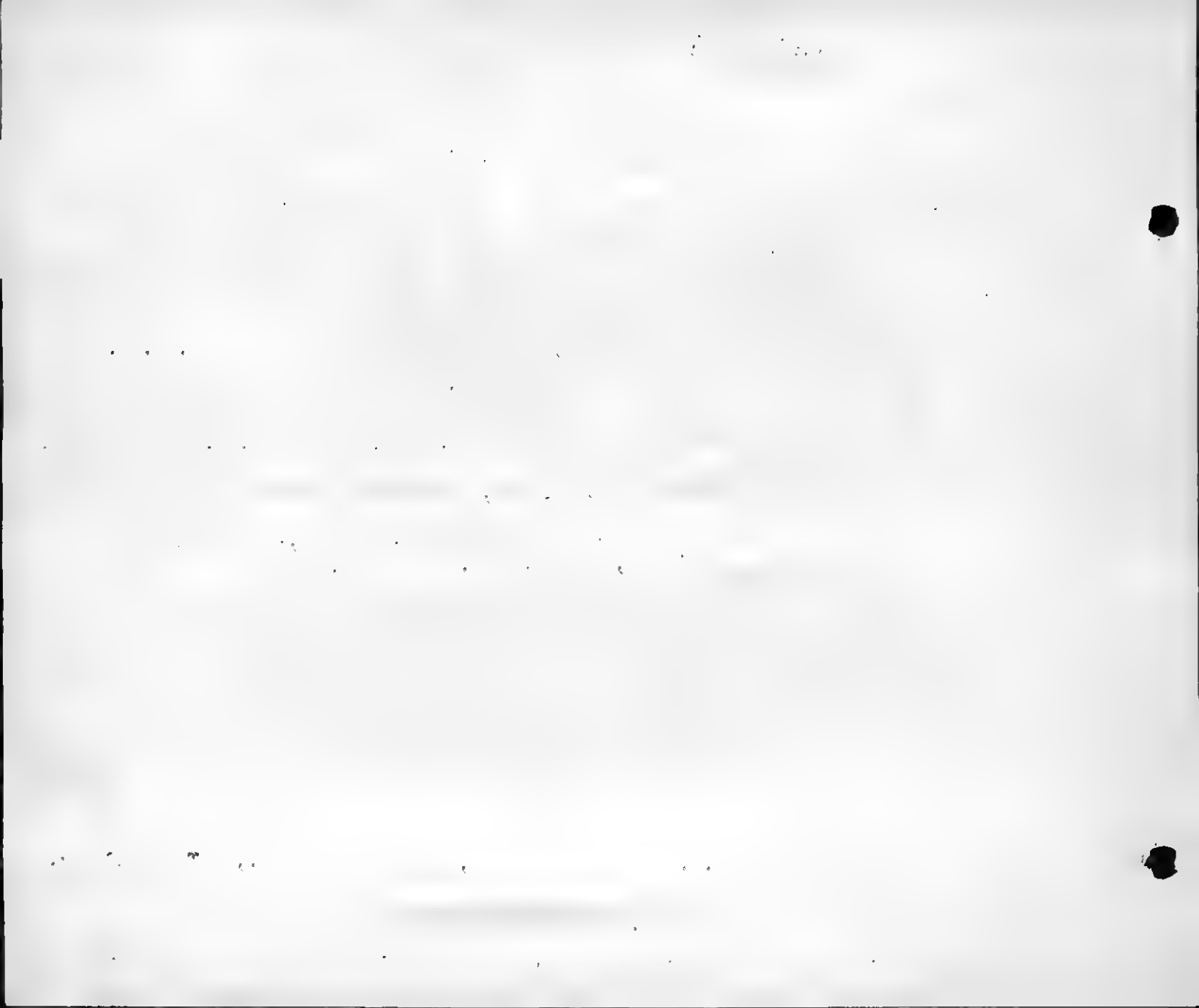
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

7830

07815

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>83 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>ELLIS</b> Middle <b>----</b> Last <b>WHITE</b>				4. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>1960</b>			
5 SEX <b>Male</b>		6 COLOR OR RACE <b>Negro</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 17, 1913</b>	
9 AGE (In years lost birthday) <b>46</b> yrs		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman - Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Nautical (Port)</b>		11 BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Ben Perry</b>				14. MOTHER'S MAIDEN NAME <b>Rosanna Wilson</b>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>				16 SOCIAL SECURITY NO <b>218-10-2984</b>			
17. INFORMANT Address <b>Clinical Rec., VAH, Baltimore 18, Md. Ft. Howard Div.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA, LEFT LUNG (REMOVED 1958)</b> 2 1/2 YRS							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>(b) METASTATIC CARCINOMA TO PARIETAL PLEURA, MEDIASTINAL LYMPH NODES, PERICARDIUM, MYOCARDIUM, RIGHT LUNG &amp; ADRENALS</b> UNKNOWN							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CACHEXIA</b>							
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from <b>April 9</b> , 19 <b>60</b> , to <b>July 1</b> , 19 <b>60</b> , that (I) (we) lost <b>1</b> saw the deceased alive on <b>July 1</b> , 19 <b>60</b> , and that death occurred at <b>1</b> M, from the causes and on the date stated above.							
22a SIGNATURE <b>Charles Allen</b> M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 22b DATE SIGNED <b>7/1/60</b>							
22c. PHYSICIAN'S NAME (Type) <b>CHARLES ALLEN, M.D.</b> 22d. ADDRESS <b>VAH, BALTIMORE 18, MD., FORT HOWARD DIV.</b>							
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				23b DATE THEREOF <b>July 7, 1960</b>			
23c NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>				23d LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b> 25a REC'D BY REGISTRAR <b>Jul 7 '60</b> 25b REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>							
Address <b>1808 N. Monroe St. Baltimore 17, Md.</b>							



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

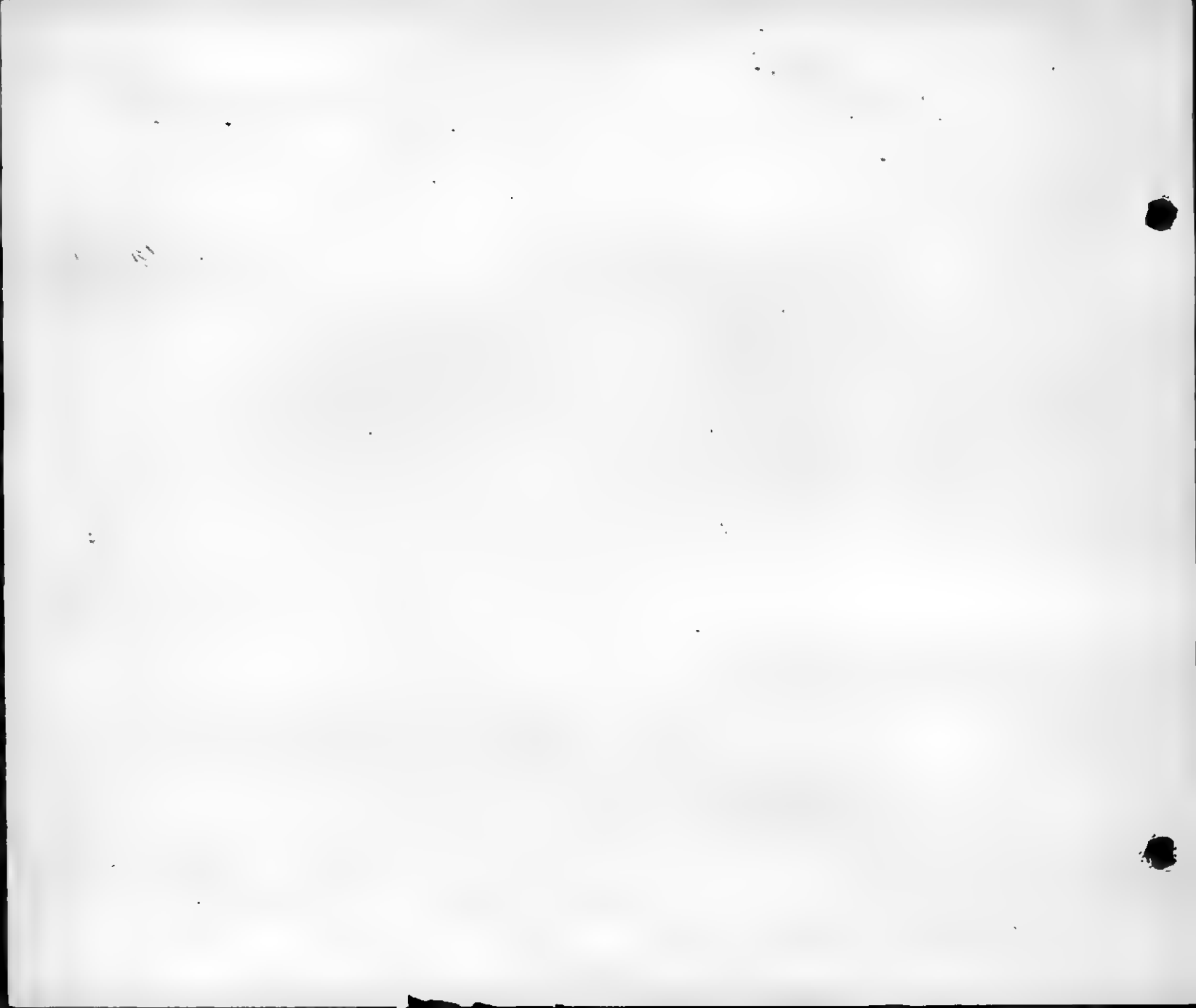
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7831

07816

1 PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Ind.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edmonsville</i>		c. LENGTH OF STAY IN 1b <i>Edmonsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Summit Home</i>		d. STREET ADDRESS <i>116 Park Dr.</i>	
3 NAME OF DECEASED (Type or print) <i>Emma I White</i> First Middle Last		4. DATE OF DEATH <i>July 10 1960</i> Month Day Year	
5 SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>3/26/82</i> 9 AGE (in years last birthday) <i>78</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Andy mfg.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ind.</i>	
11. BIRTHPLACE (State or foreign country) <i>Ind.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>J. Bowling</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>yes</i> 17. INFORMANT <i>Melvin S. White</i> Address	
18. CAUSE OF DEATH (Enter only one cause operative for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Terminal Hypertensive Hemorrhage</i> DUE TO <i>Cardiovascular Renal Disease &amp; C</i> Conditions if any which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>arteriosclerosis</i> (c) <i>arteriosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>20 months</i>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>fracture left femur 2/14/60</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <i>9/4</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <i>9/4</i> 19 <i>60</i> to <i>7/10</i> 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>7/7</i> 19 <i>60</i> , and that death occurred at <i>4 P</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>E. W. Johnson</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>E. W. JOHNSON</i>		22d. ADDRESS <i>3432 FREDERICK AVE 29</i>	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
<i>Burial</i>		<i>7/13/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>London Park</i>		23d. LOCATION (City, town, or county) (State) <i>Balto. Ind.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Mac Platt &amp; Son</i>		25a. REC'D BY REGISTRAR DATE <i>JUL 13 '60</i>	
ADDRESS <i>28</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	

(M)



7691

CERTIFICATE OF DEATH

Reg. Dist. No. 02817

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glyndon</b>				c. LENGTH OF STAY in 1b <b>14 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>14 Ames Place</b>				d. STREET ADDRESS <b>1604 C Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Rebecca</b> Middle <b>Jane</b> Last <b>White</b>				4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 30, 1868</b>	
9. AGE (In years last birthday) <b>91</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Thomas Mason</b>				14. MOTHER'S MAIDEN NAME <b>Julia Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Mary Ross, 14 Ames Place, Glyndon, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>422.01</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic C-V Disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b>  <b>1 yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Umbilical Hernia</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	
20f. (City or town) <b>none</b>				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>7-17-59</b> , 19____, to <b>7-5-60</b> , 19____, that I last saw the deceased alive on <b>7-3-60</b> , 19____, and that death occurred at <b>7 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6 Hanover Rd.</b> DATE SIGNED <b>7-5-60</b>							
ACTUAL SIGNATURE <b>D. D. Caples</b>				M.D. <b>6 Hanover Rd.</b>			
PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>				Reisterstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/8/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley</b>				ADDRESS <b>Dundalk 22, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 8 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 07818

7832

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b <u>LTC.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>301 W. Chesapeake Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alice G Zellers</u>		4. DATE OF DEATH <u>July 6 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Roberts</u>		14. MOTHER'S MAIDEN NAME <u>Catherine O'Brian</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>1111 Overbrook Rd</u>	
17. INFORMANT <u>Mrs Isabelle Clark</u>		Address <u>1111 Overbrook Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiovascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease &gt; 15 yrs.</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 1959</u> to <u>July 6, 1960</u> , that I last saw the deceased alive on <u>July 6, 1960</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1211 NORTHERN PKWY. BALTO. 12, MD</u> DATE SIGNED <u>7/6/60</u>			
ACTUAL SIGNATURE <u>Robert W. Gebhardt M.D.</u>		PHYSICIAN'S NAME (Type) <u>ROBERT W. GEBHARDT</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 9, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas F. Evans &amp; Son</u>		ADDRESS <u>8802 Hartford Rd</u>	
24a. REC'D BY REGISTRAR <u>JUL 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND—DEPARTMENT OF GENERAL SERVICES

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1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FT HOWARD</b> c. LENGTH OF STAY IN lb <b>2 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>5607 LIBERTY HEIGHTS AVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Served as: Albert ALBERT</b> Middle <b>W</b> Last <b>ZIEMAN</b> <b>ZIEMANN</b>		4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 2, 1893</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR: Months <b>67</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION CO</b>	
11. BIRTHPLACE (State or foreign country) <b>WOODLAWN, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>August Ziemann</b>		14. MOTHER'S MAIDEN NAME <b>Emma Felgner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>215-09-7528</b>	
17. INFORMANT <b>Clin. Rec. VAH Balto 18, Md Ft Howard Division</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MASSIVE GASTROINTESTINAL HEMORRHAGE</b> DUE TO <b>ACUTE MYELOID LEUKEMIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 Week</b> <b>14 months</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>8:20A</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>July 27</b> <b>1960</b> to <b>July 29</b> <b>1960</b> , that (we) last saw the deceased alive on <b>July 29</b> <b>1960</b> , and that death occurred at <b>8:20A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter J. Pijanowski</b>		22b. DATE <b>7/29/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER J. PIJANOWSKI</b>		22d. ADDRESS <b>VAH Ft Howard Div. Balto 18, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-1-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) (State) <b>Balto. Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight</b>		25a. REC'D BY REGISTRAR <b>AUG 3 '60</b>	
ADDRESS <b>6009 Harford Rd Balto Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

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THE STATE OF NEW YORK  
IN SENATE  
JANUARY 1837  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN ANSWER TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1836  
ALBANY: PUBLISHED BY  
J. B. LEECH, 1837